

This Scanning Electron Micrograph (7000X) is the first 3-dimensional view of a cell in an ulcerated duodenum. The center is completely denuded, surrounded by fairly well-preserved microvilli. This SEM photomicrograph was taken from a scientific exhibit which won the Hull Award as the "best exhibit on original research or instruction on a medical subject" at the A.M.A. Clinical Convention, November 26-29, 1972, in Cincinnati, Ohio.

The Tireless Man

whose duodenal ulcer needs a rest

Up early, home late, often with a scratch pad filled with notes, figures, plans. A few hours' sleep and then another long day. This is often the routine of the tireless hard driver, one-man committee with enough overwork and stress to wear out several men. But his duodenal ulcer may warn him with sharp discomfort that he had better ease up, let some things go, and give himself—and his ulcer—a rest.

The need to reduce G.I. hypermotility and hypersecretion

Overwork together with overanxiety are often principal factors in exacerbating a duodenal ulcer. To help reduce the increased gastric secretions and hypermotility, therapy may need to include treatment for associated undue anxiety—which is where dual-action Librax can be highly useful.

The dual nature of Librax

Only Librax combines, in one capsule, the antianxiety action of Librium® (chlordiazepoxide HCl) and the antisecretory action of Quazaran® (clidinium bromide).

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Symptomatic relief of hypersecretion, hypermotility and anxiety and tension states associated with organic or functional gastrointestinal disorders and as adjunctive therapy in the management of peptic ulcer, gastritis, duodenitis, irritable bowel syndrome, spastic colitis, and mild ulcerative colitis.

Contraindications: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage without withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of child-

bearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, agitation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants. A causal relationship has not been established clinically.

Adverse Reactions: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly,

and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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For optimal response, dosage should be adjusted to your patient's requirements—1 or 2 capsules, 3 or 4 times daily. Rx: Librax #35 for initial evaluation of patient response to therapy. Rx: Librax #100 for follow-up therapy—this prescription for 2 or 3 weeks' medication can help maintain patient gains while permitting less frequent visits.

For the anxiety-linked symptoms of duodenal ulcer

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Librax

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

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Medical Tribune

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and Medical News

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world news of medicine and its practice—fast, accurate, complete

Wednesday, October 3, 1973

Tropical Diseases on Upturn In N. America, Experts Warn

Medical Tribune Report

NEW YORK—Two radiologists with extensive firsthand knowledge of tropical diseases warned here that such disorders are now turning up with increased frequency in North America.

Urging U.S. clinicians to become more familiar with the symptoms of these "unwanted immigrants," Drs. W. Peter Cockshott, of Canada's McMaster University, and Mauricio M. Reeder, of Walter Reed Army Medical Center, pointed out that rapid transportation and population mobility have breached old geographic barriers.

The fact that some of these diseases simulate more common ailments often leads to misdiagnoses, the specialists told a Medical X-Ray Forum sponsored by the American College of Radiology and Eastman Kodak Company.

"In perplexing clinical problems, a history of recent travel or a stay out of the country are important aspects of case history taking for practitioners," said Dr. Cockshott, whose experience includes 11 years at hospitals and universities in Nigeria.

He noted that most of the exotic diseases seen in immigrants or returning visitors—especially diseases of the classic "tropical" type—are best detected by a combination of blood studies and examination of stool and urine to supplement physical examination and chest x-ray.

A radiologic approach to diagnosis is thus not usually primary, but Dr. Cockshott stressed that it can take on "vital importance" if patients are seen in a later stage of certain diseases.

"There are many disorders where the laboratory findings may be negative initially," he said.

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Radiograph of a Puerto Rican patient, living in New York, with Schistosomiasis mansoni. The rectosigmoid colon exhibits rigidity, narrowing, and shortening.

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• Exclusive interview with biophysicist Efraim Katzir, President of Israel pg. 9.

• World-wide increase in respiratory ailments forecast pg. 21.

• SPORTS: Prompt surgery urged for tears in thumb ligament, pg. 31.
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Edwards Given Powers to Act As Health Chief

Medical Tribune Report

WASHINGTON—The Department of Health, Education, and Welfare has quietly consolidated control of policy and planning of all its health care operations under Dr. Charles C. Edwards, the Assistant Secretary for Health—making him the Administration's de facto "health czar."

Although Dr. Edwards' title suggests the authority and responsibility he now in fact has, his office did not previously possess such significant influence over HEW's enormous and nebulous health care divisions.

Despite an organization that includes coequal assistant secretaries for planning and evaluation and for legislation, much of the health care planning will now be directed from Dr. Edwards' office, and health care planning and policy of the other HEW divisions, including the Social Security Administration (Medicare) and the Social and Rehabilitation Service (Medicaid), will have to be channeled through and approved by Dr. Edwards.

The move, which was ordered by HEW Secretary Caspar W. Weinberger—one of President Nixon's most trusted administrators—gives Dr. Edwards, in addition to control of HEW's health policies, the power to initiate and, if necessary, to veto, health policy decisions.

Dr. Edwards, as the Administration's health chief, is now developing a cohesive National Health Strategy and trying to organize the Federal health care system into a relatively unified, viable force. The aim is to exert more influence on the health care delivery industry, to obtain more service for each Federal health care dollar spent, to spend fewer dollars while improving the quality of health care in general, and to bring the lumbering HEW health care giant under more effective control in anticipation of the upheaval that the coming of National Health Insurance may bring—and of the demand for services that this is likely to create.

Dr. Edwards had earlier complained that

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Doctors' Wives Are Moving To Assert Separate Identity

Medical Tribune Report

The rising feminine consciousness has created some rebels among doctors' wives. Are they women's libbers? Yes and no. "I suppose, in the purest sense, I am a feminist," says one, "but I don't fall into the current group of activists, who seem to be upset over their initial sex determination." Instead, these women feel that their personal fulfillment, as well as the very survival of their marriages, may not depend on a full-fledged career but does entail a change in the way they see themselves—no longer basking in the reflected glory of their husbands' positions.

"The M.D. begins to look down on the woman who stands there waiting with the slippers and refreshments at the door," says the wife of an ophthalmologist. "It's really sad that an intelligent woman who has all this ability and is trying to be a helpmate ends up with her husband not respecting her."

"M.D.s associate with other M.D.s at the hospital, with intelligent people. Then they come home and hear how the refrigerator broke, hear all the household



trivia. Eventually, they may come to think they've married a blithering idiot."

Even if the marriage can hobble along under such circumstances, the unfulfilled wife suffers. And doctors' wives see the

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High Competence Seen Risk Factor For Patient Suits

Medical Tribune Report

CLEVELAND—Often it is the "highly competent" physician, rather than the inept one, who is sued for malpractice, Dr. Monroe E. Trout, president of the American College of Legal Medicine, declared here.

This was his impression from hearings held all over the country by the Commission on Malpractice sponsored by the Secretary of Health, Education, and Welfare. This impression, Dr. Trout said, was confirmed by the testimony of representatives of the specialty boards, who told of many instances in which the outstanding men in their fields were being sued.

He explained that these are the physicians who are "very often willing to take over the difficult problems."

Dr. Trout, who was a member of the commission, said that its figures show that orthopedic surgeons and anesthesiologists are most likely to be sued, followed by general surgeons, obstetricians and gynecologists, and general practitioners.

Continued on page 4

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See Page 3 for Details



MDs Advised to Accept Use Of Anabolic Steroids in Sports

Medical Tribune World Service

HAMILTON, NEW ZEALAND—The use of anabolic steroids by certain types of athlete to build weight and muscle is a fact of life, and the medical profession should accept it realistically, in the opinion of a British physician.

The role of the doctor should be to attempt to persuade those using steroids to take them in dosages that are unlikely to cause harm, according to Dr. John G. P. Williams, medical director of Farnham Park Rehabilitation Center and a consultant in physical medicine at Mount Vernon Hospital.

Dr. Williams, who was speaking at the biennial conference of the New Zealand Federation of Sports Medicine here, said that a number of controlled studies have shown that anabolic steroids can be used constructively and relatively safely.

Later, in a MEDICAL TRIBUNE interview, he explained that he does not encourage patients to take steroids, "but when an athlete patient tells me he is going to take

steroids, and he is determined to do it, I ask him to do it under my supervision."

"I prescribe a relatively low dosage and follow through to check results and watch for any side effects. If athletes are going to take such drugs, we may as well have it done under conditions where we can learn something about their effects."

The prescription is given only after a medical examination, and Dr. Williams requires regular medical checks during treatment.

Medical Tribune World Service

AUCKLAND, NEW ZEALAND—A leading official of the New Zealand Federation of Sports Medicine, Dr. Warwick M. Smeeton of this city, said he was "appalled" at Dr. John G. P. Williams' defense of the prescription of anabolic steroids to athletes.

"We cannot accept his line of reasoning," he said. "The drugs are banned by the Olympic and Commonwealth Games bodies and rightly so."

Hospital for the Jet Set



The Instituto Médico Costa del Sol recently opened on Spain's sunny coast. Known as Incosol, it is a combination luxury resort and health care center for the patient who wants both at once.

news index

CLINICAL NEWS NOTE: "In perplexing clinical problems, a history of recent travel or a stay out of the country are important aspects of case history taking for practitioners." (Dr. W. Peter Cockshott; see page 1.)

Medicine: pgs. 1, 2, 5, 9, 16, 17, 21, 25, 29

Limited genetic information regarding diabetes makes it difficult to offer genetic counseling or to attempt eugenic measures

Tuberculosis program in Texas provides services to residents of 254 counties covering 275,416 square miles

Diabetes studies of East and West show striking differences in incidence and complications of diabetes

Respiratory virus increase is forecast in people and animals throughout the world in the next 30-40 years

Food contamination is causing increasing concern in Japan, where food poisoning has risen recently

Ob/Gyn: pgs. 2, 17

"Managed childbirth" using oxytocin is recommended for wider use by the physician who perfected the technique

Psychiatry

Telephone distress calls should be handled by a physician, preferably a psychiatrist, according to a suggestion by a Warsaw physician

Research: pgs. 5, 8, 31

Cancer cell growth may be cut by phenylalanine ammonia-lyase, which destroys an essential amino acid in the blood that cancer cells cannot live without

Responsiveness of rats to certain centrally acting drugs has been found to increase with age

Surgery

Prompt surgery is recommended for injury to the ulnar collateral ligament of the metacarpophalangeal joint of the thumb, a frequent occurrence in sports

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Diabetic Impotence Unrelated to Treatment

Medical Tribune World Service

BRUSSELS—Diabetic impotence seems to occur regardless of the duration or mode of treatment, whether with insulin or with oral agents, Dr. D. M. Barnett, of the

Canadian GPs Increase

MONTREAL—Canada's Medicare system has had one notable result—three of four medical school graduates are going into general practice. "The fundamental reason is the great financial attractiveness of general practice," said Dr. Jacques Genest, director of Montreal's Clinical Research Institute.

Joslin Clinic, Boston, said here at the eighth Diabetes Congress.

In a study of sexual function in 175 male outpatients, he and associates found that 85 (49 per cent) were impotent, while four others suffered premature ejaculation and two retrograde ejaculation.

There appeared to be some correlation with age and duration of disease, Dr. Barnett reported, the impotent patients showing a mean age of 53 with duration of disease six years. Patients who retained potency were younger (mean 45) and had been diabetic for about five years. Peripheral neuropathy was more common in the impotent group.

Co-workers with Dr. Barnett were Drs. R. C. Kolodny, C. B. Kahn, and H. H. Goldstein.

Another group of investigators, from the Durand Hospital, Buenos Aires, expressed the belief that diabetic sexual dysfunction is caused by a "neurological lesion of the nerve fibers that control erection." The conclusion resulted from an autopsy study in which they removed and microscopically examined autonomic fibers from the corpora cavernosa of five impotent diabetics and five nondiabetic controls.

The investigators, Drs. I. Faerman, L. Glocer, D. Fox, M. N. Jadzinsky, and M. Rapaport, reported that four of the five diabetics (mean age 53, mean duration of disease seven years) exhibited morphologic changes in the fibers comparable with those previously described in diabetic bladder nerves. No signs of penile nerve defects were found in the five control corpses.

Use of Oxytocin Urged In 'Managed Childbirth'

Medical Tribune World Service

DUBLIN—Wider use of the "managed childbirth" technique using oxytocin, by which no mother need spend more than 12 hours in labor, was urged here by the man who perfected it.

Dr. Kieran O'Driscoll, Professor of Obstetrics at University College, said:

"The system does not involve the artificial stimulation of birth. It is a process of acceleration. We wait until nature has pressed the button and then we speed the natural process. This is done by the rupture of the membranes and then infusion of oxytocin."

"There is no danger and no side effects. Hospitals should cast off their conservative notions and adopt the systematic use of the drug."

Dr. O'Driscoll said that the method has proved successful with some 30,000 patients at the National Maternity Hospital here. In some cases labor has been reduced to as little as six or eight hours. The use of analgesics has also been reduced.

Special Ambulances Tried

Medical Tribune World Service

UTRECHT, THE NETHERLANDS—Expensive special ambulances to handle emergency cardiac cases have been found to give little or no benefit here.

During a 30-month trial period about 650 "acute" cases were handled, divided about equally between the special service and ordinary ambulances. A review has indicated no difference in mortality.

The special ambulances cost twice as much as ordinary ambulances.

Breast Cancer: earlier warning system

Futility and frustration beset the physician confronted with breast cancer. For the last 35 years, the survival rate has not significantly changed despite intensive educational programs aimed at earlier detection, and improvement in treatment techniques.

What is the outlook? We know the key to reducing mortality from breast cancer is in the earliest possible diagnosis. The stage at which breast cancer is detected is crucial to the outcome of treatment. By the time a lump is discovered through BSE or clinical examination, critical time may have been lost.

And we do have the means to achieve earlier diagnosis. We do have an earlier warning system. Mammography and thermography can detect breast cancer before a lump is discernible by palpation.

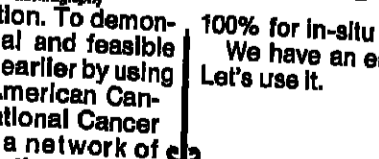
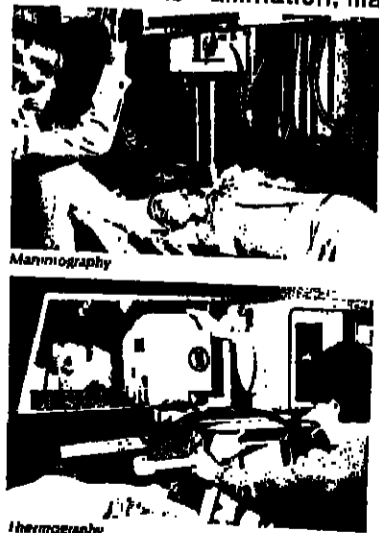
To demonstrate that it is practical and feasible to detect breast cancer earlier by using these modalities, the American Cancer Society and the National Cancer Institute are funding a network of breast cancer demonstration projects. Supported by grants of \$2-million from

the ACS and \$4-million from the NCI, 20 such centers are expected to be operative across the country by the end of the year. Each will screen at no charge, approximately 5,000 women annually, in what is considered to be the ideal detection program—to include clinical examination, mammography and thermography. Each of these detection methods contributes independently to the detection of breast cancer, and none can be dispensed with in the search for early disease.

At present we cannot prevent breast cancer, but the potential for saving more lives is immense. The five-year survival rate surges dramatically from 53% when axillary nodes are positive, to approximately 85% when the disease is localized, to nearly 100% for in-situ cancer.

We have an earlier warning system. Let's use it.

american cancer society



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4

NAME _____

ADDRESS _____

CITY _____

STATE _____

ZIP _____

AGE: ☐ UNDER 40 ☐ 40-55 ☐ OVER 65

PRACTICE ☐ GENERAL ☐ SPECIALTY _____

APPROXIMATE NUMBER OF PATIENTS SEEN WEEKLY

☐ LESS THAN 60 ☐ 50-100 ☐ MORE THAN 100

APPROXIMATE % OF PRACTICE TIME SPENT IN HOSPITAL

☐ 10% ☐ 25% ☐ 50% ☐ OVER 50%

Tropical Diseases on Upturn In N. America, Experts Warn

Continued from page 1

tially because the lesion is deep-seated and can only be displayed by radiologic or nuclear medicine methods," he said. Dr. Cockshot also pointed out that complete laboratory studies are sometimes not undertaken because the physician does not suspect the presence of an "immigrant" disease.

Term Is a Misnomer

Both radiologists commented that the term "tropical disease" is a misnomer. It is applied to a number of disorders once common in temperate climates, they explained, and can best be understood as just a label for conditions not now endemic to North America.

Speaking in tandem, Drs. Cockshot and Reeder discussed nearly two dozen exotic diseases but gave special emphasis to the following entities:

- **Ameliasis**—probably the number-one parasitic disease of our society, according to Dr. Reeder. Radiologic studies can be of "considerable help" in diagnosis of the chronic form since it is usually characterized by presence of colon spasm, cone-

shaped cecum, ulcers, so-called apple-core constriction of colon, and abscesses of liver or lung. Patients have been misdiagnosed as having Crohn's disease, ulcerative colitis, cancer.

- **Schistosomiasis**—200,000,000 people around the world are afflicted with some type, and Schistosomiasis mansoni is estimated to be present in one of 10 Puerto Ricans now living in New York City. The radiologist sees changes in intestinal mucosa, spasms, fibrosis, narrowing of the bowel. The long period—sometimes years—between infestation and manifestation of disease can lead to delayed or wrong diagnosis unless clinicians are aware of a patient's background, Dr. Reeder said. Symptoms are occasionally mistaken for those of Crohn's disease or duodenal ulcer.

- **Chagas' disease**—associated chiefly with South and Central America, particularly eastern Brazil, but cases have occurred in Mexico and Texas. In the chronic stage—reached 10 to 20 years after being bitten by the bug—patients develop massive dilation of colon with retention of feces, enormous hearts, dilated outpouching of heart chambers, achalasia of the esophagus.

Dr. Cockshot pointed out that the disease may be contracted by members of the Peace Corps or other volunteers who work and live in poverty-stricken areas of South and Central America. Dr. Reeder reported a case seen in Washington, where the typical symptoms of the chronic stage were eventually recognized in an employee of the Brazilian Embassy.

- **Giardiasis**—like amebiasis, picked up by travelers or servicemen and brought in by people emigrating to this country. Examination of stools usually permits quick diagnosis, Dr. Reeder said, but x-ray studies will demonstrate the characteristic ulceration and spasm of the proximal portion of the small bowel with normal findings in the distal portion.

- **Ascariasis**—by no means strictly an "immigrant" disease but may occasionally be difficult to detect unless the examining physician is suspicious. Dr. Reeder calls it a "not uncommon cause" of bronchial pneumonia in some areas of the country.

- **Melioidosis**—virtually unknown to U.S. physicians until servicemen in Vietnam began showing up with a disease marked by small abscesses in lungs, brain, liver, and other organs. Investigation revealed that the disorder (caused by *Pseudomonas pseudomallei*) is prevalent in subclinical form in the native population, Dr. Reeder said. Patients may not manifest overt symptoms for two to three years after exposure, and the combination of pneumonitis and lung cavitation has led to the misdiagnosis of tuberculosis in some cases.

Pittsburgh Gets Skull



One of three existing Spalteholz Skulls has been donated to the University of Pittsburgh School of Dental Medicine by Dr. Lewis Etter. The translucent quality of the skull was achieved through a special bone-treating process developed by the renowned German anatomist, Prof. Werner Spalteholz.

Hospital Unit Gauges Function of Pacers In Nearby Patients

Medical Tribune Report

ALBANY, N.Y.—Albany Medical Center Hospital has established a clinic to electronically monitor the functioning of cardiac pacemakers implanted in some 400 men and women in the area.

Dr. Jack Han, Professor of Medicine at the Albany Medical College and director of electrocardiography at the Albany Medical Center Hospital, said the new clinic assists physicians in the care of these patients by doing regular follow-up examinations and predicting the impending failure of battery-powered pacers.

Dr. Han said the rate of success in predicting impending failures is about 90 per cent and that the regular follow-up procedure will allow patients to be hospitalized for the replacement of pacemakers on an elective instead of an emergency basis.



"GALVESTON—Slap a wet towel over a man's face and his heart will slow down, a cause-effect relationship called dive reflex."

—News release from the University of Texas Medical Branch. There's another kind of dive reflex, and we recommend that you use that one right after you slap the wet towel over the guy's face.

(Regular beat: Immateria Medica, page 31.)

Edwards Gets Power Of Policy Control, Now Health Chief

By NEIL L. CHAYET
Member of the bar, Massachusetts
and District of Columbia

Continued from page 1

"We have heard simultaneously from a National Institutes of Health voice, a Food and Drug Administration voice, . . . and others, each with its own parochial state on what Federal health policy ought to be and each frequently in conflict with one or more of the other voices in the HEW chorus."

"If the Federal Government is going to participate effectively in developing a National Health Strategy, we first have to make sure that we are not divided among ourselves and working at cross-purposes."

In no uncertain terms, Mr. Weinberger told all of HEW's assistant secretaries, agency heads, and regional directors that Dr. Edwards is "the key element in the established departmental processes for health policy development." They were informed that the reorganization is intended "to ensure that our health policies are coherently and consistently enunciated both within and without the department."

Actions Need His Approval

Further, it was ordered that the "Social Security Administration and the Social and Rehabilitation Service will take no action that has a measurable impact on, or is up to draw a significant reaction from, the medical community without the concurrence from the Assistant Secretary for Health before it becomes final."

"On the other hand, SSA and SRS have the authority to carry out their own assignments at their own initiative, but such activities, wherever they involve a significant change or impact on such things as certification of facilities, peer review, utilization review, etc., must be concurred in by the Assistant Secretary for Health."

Among the obstacles that Dr. Edwards faces in running the Government's health affairs are the Washington bureaucracy and the rumored impending resignation of Mr. Weinberger to run for public office in California—a rumor that Mr. Weinberger no longer directly denies.

Another rumor circulating here is that Dr. Edwards will himself resign to become the American Medical Association's executive vice-president. Reliable sources discount this whispering, however, pointing out that he now has the most important health affairs post in the nation and has just begun to make his impact felt.

Hospitals Raise Rates

Medical Tribune Report

HARTFORD, CONN.—In the past few weeks, most of Connecticut's 34 general hospitals have announced rate increases, up to \$133 a day.

Confidentiality: 'There's a Police Officer in the Waiting Room'

Watergate and the disclosure of the burglary of the office of Dr. Lewis J. Felding, Daniel Ellsberg's psychiatrist, in an attempted violation of privileged information, has raised anxieties. Here a man of law deals with one aspect.

Your nurse is standing before you and has just said, "There's a police officer in the waiting room, and he's asking questions about one of your patients." Should you face him and answer his inquiries, firmly tell him you refuse to answer any questions, or simply leave by the back door?

The frequent demands upon physicians for information about their patients constitute a major threat to the sanctity of the physician-patient relationship. Government agencies, police, insurance companies, employers, and the military seem to be involved in incessant information gathering, which frequently places you in a dilemma posed by the apparent needs of society, on the one hand, and the sanctity of the physician-patient relationship, on the other. What are the guidelines which can help you serve both your patients and the dictates of society?

Rhetically, the answer is clear: one should not divulge confidential information about one's patients without their consent. The only exception to this rule is if the doctor is convinced that failure to divulge certain information will subject the person himself or other persons to serious bodily harm or if the law requires a disclosure of information—as, for example, in the case of bullet wounds, drug abuse, venereal disease, or other areas where a state legislature has made the decision that the importance of the information overrides the sanctity of the physician-patient relationship.

Government officials have from time to time expressed opinions which relegate the rights of the individual to an inferior position. J. Edgar Hoover, writing in the *Journal of the American Medical Association*, stated that physicians must help protect the nation's internal security by reporting to the FBI any information relevant to such security which might come into his possession. Adding a metaphor out of deference to his readership, he added: "We must kill these Communist germs and increase the strength and vigor of American resistance."

Process Short-Circuited

The testimony of John Ehrlichman at the Senate Watergate Hearings is proof that wholesale checks on the privacy of the physician-patient relationship did not die with Mr. Hoover; in fact, in the Ellsberg case, the process is short-circuited by the Government's not even bothering to request the information from the psychiatrist involved. Assuming that doctors generally still have the choice of whether or not to give out information, however, let us look at the general principle of disclosure stated above and see how the ethical principle is supported by the law.

Legal precedent in the area is sparse. The earliest case on record dealing with confidential communications to a physician involved a church elder whose wife bore him a child after she had been married to him for only six months. The kirk session, or church council, decided that an investigation was definitely in order and ordered the elder to secure the services of a physician who would examine the child and certify that it was premature. A doctor was selected by the father and, having examined the child and found that it was clearly not premature, delivered a copy of his findings to the church officials. The father was dismissed in shame and sued the physician for improperly disclosing confidential information. Relying behind the father, the court stated "that a medical man, consulted in a matter of delicacy, of which disclosure may be most injurious to the feelings, and possibly the pecuniary interests of the party consulting can gratuitously and unnecessarily make it the subject of public communication . . . is a proposition to which, when thus broadly held down, I think the court will hardly give their countenance. . . . If it could have been doubted that such a confidential re-

lation subsists between a medical man and his employer, I think it high time that such a doubt should now be set at rest forever."

This opinion was rendered in 1851 and appears to be about the last case which clearly stood behind the ethical duty to maintain confidence. In a modern-day counterpart, a New Jersey pediatrician was asked to examine an infant and supposedly informed the father that the baby was in good health, and the father promptly insured the child's life. When the child suddenly died, the insurance company contacted the doctor, who advised the company, without permission of the parents, that the baby had heart trouble since birth. The court, while stating that the doctor was under a general duty not to disclose frivolously any information received from the parents, found that there was sufficient redeeming social importance to the purpose of the doctor's disclosure (an attempt to prevent insurance fraud). This standard, distur-

ingly similar to that by which pornography is judged, makes it clear that courts will go to great lengths to protect the doctor making the disclosure—as long as he is attempting to serve some worth-while social purpose.

Doctor Held Responsible

Other cases have made it clear, however, that the doctor who discloses information as idle gossip or for his own personal gain will be held responsible to his patient. In one case, the father of a bride-to-be inquired of a psychiatrist who was treating the prospective bridegroom as to what was wrong with his future son-in-law. The psychiatrist readily answered the inquiry, stating that he had diagnosed the individual in question as a "manic-depressive and a psychopathic personality," concluding with the statement: "My suggestion to the infatuated girl would be to run as fast and as far as she possibly can in any direction away from him." The girl promptly married the fellow and was

disinherited by her parents; bride and groom then joined in a lawsuit against the psychiatrist. The court, in finding against the psychiatrist, stated:

"It is recognized that ordinarily the truth is a defense to an action for libel or slander. However, in the instant case there is the special circumstance to reckon with that a doctor-patient relationship existed between the parties . . . it is our opinion that if the doctor violated that confidence . . . an action would lie for any injury suffered."

Other cases that have gone against the physician are even more blatant; in one, an obstetrician filmed his patient while he performed a cesarean section and then sold the film without her consent for public viewing in the New York City public theaters.

The general rule, then, is to make no disclosure without the full consent of the patient (in writing, if at all possible). Even where there is consent, the physician owes it to his patient to make certain that the patient is competent to give his consent and is giving it freely, and the doctor should be aware whenever possible of who

Continued on page 31

Brain Ethanol Up In Drunk Goldfish Via Preconditioning

Medical Tribune Report

EAST LANSING, MICH.—Goldfish that have acquired a tolerance to alcohol, when challenged with a 3.1 per cent solution, have a higher concentration of brain ethanol at the point of their getting drunk and turning over in the tank than fish that have not been preconditioned.

The procedure for the studies, presented here to the American Society for Pharmacology and Experimental Therapeutics, was to pre-expose different groups of goldfish to EtOH solutions of 0.4, 0.8, or 1 per cent, for periods ranging from three hours to 10 days, before immersing them in the 3.1 per cent challenge solution. A control group went into the drunk tank cold sober.

The group of fish pre-exposed to the 1 per cent solution were eliminated from the study because "ataxia and spontaneous overturn appeared in one hour or longer; approximately half of the fish died between the second and 10th day of continuous exposure," according to the investigators, Hebe B. Greizerstein, Ph.D., and Dr. Cedric M. Smith, of the New York State Department of Mental Hygiene's Research Institute on Alcoholism and the State University of New York at Buffalo School of Medicine.

At the moment of its helpless overturn in the challenge solution, each fish was removed and its brain EtOH was analyzed. The team found that the mean brain EtOH of the control group ranged from 3.6 to 4.5 micrograms/mg. brain; the range for fish with pre-exposure at 0.4 per cent was 5.4 to 6.6; and with a pre-exposure at 0.8 per cent it was still higher.

Patient Learns About Adrenal Scan



Smaller and smaller glandular tissue abnormalities are being detected by nuclear medicine techniques developed by Dr. William H. Bolterwalter and colleagues at the University of Michigan. Here, he explains a procedure that uses radiolabels to diagnose adrenal diseases to a patient about to undergo an adrenal scan.

Lack of Diabetes Knowledge Limits Genetic Counseling, Eugenic Measures

Medical Tribune World Service

BRUSSELS—The genetic background of diabetes is unknown territory, said Dr. David L. Rimon, Professor of Pediatrics and Medicine at the University of California at Los Angeles.

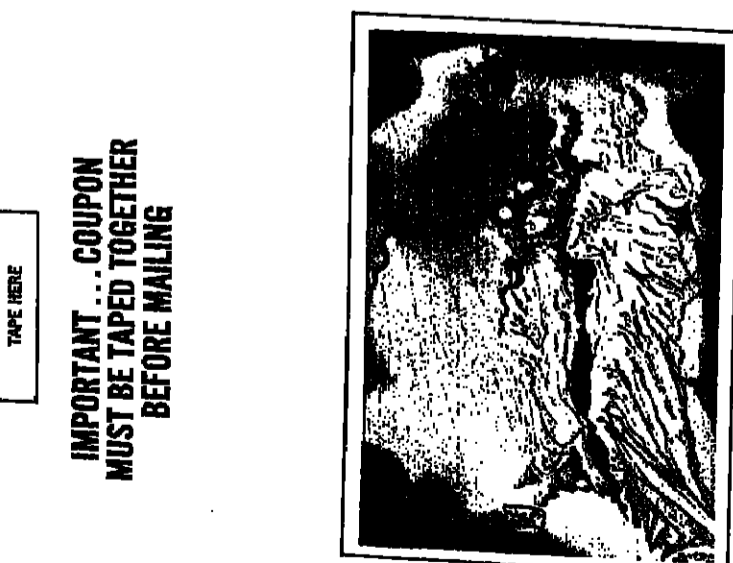
"With our limited knowledge concerning the genetics of diabetes, it is difficult to offer informative genetic counseling to an individual couple and foolhardy to attempt eugenic measures," he told the eighth Diabetes Congress here.

Hereditary Factors Important

Hereditary factors are generally accepted to be of great importance in the etiology of diabetes, he said, but there is little agreement as to the nature of the genetic mechanisms. Regardless of the marker used, be it clinical diabetes or abnormal glucose tolerance, there is a significantly greater prevalence of abnormality among the relatives of diabetics than among similar relatives of nondiabetics.

But in almost none of the studies, Dr. Rimon said, have individual family units been examined, nor has there been any attempt to define different genetic forms of diabetes. Although the evidence derived from studies of familial aggregation and twins leaves no doubt as to the importance of genetic factors in the etiology of diabetes, the mode of inheritance of the diabetic trait or traits is unknown, he stated.

The most important impediment to genetic analysis, Dr. Rimon said, is the lack of knowledge on basic defects, and there is no sure way of detecting prediabetics.



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ROCHE announces
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BACTRIMTM

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

a new type of antibacterial
for a two-pronged attack
against chronic urinary
tract infections due to
susceptible organisms

Bactrim is highly effective in the treatment of these infections — primarily pyelonephritis, pyelitis and cystitis — when due to susceptible organisms. This efficacy is related to the unique mode of action against bacteria (see illustration), an action that, in effect, makes Bactrim a new type of antibacterial.

Bactrim interrupts the life cycle of susceptible bacteria

Unique mode of action interrupts the life cycle at two important points, thereby impeding the production of nucleic acids and proteins essential to these bacteria. These consecutive interruptions occur because sulfamethoxazole and trimethoprim resemble naturally existing substrates. By competitive replacement of these substrates, they inhibit further synthesis.

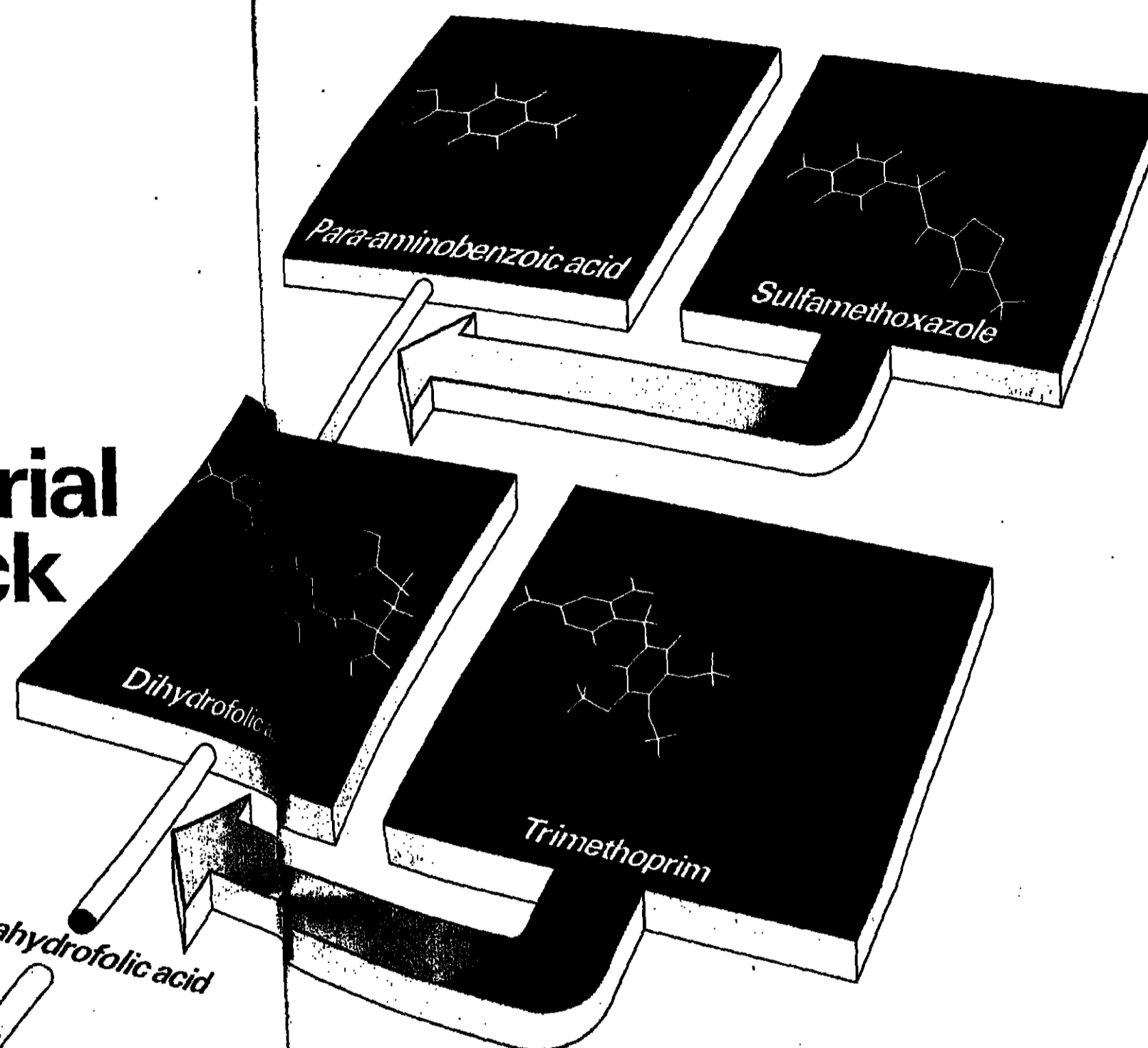
Prescribing considerations

Clinical Limitations: Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections. Not recommended for children under twelve.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period.

Warnings and Precautions: Both sulfamethoxazole and trimethoprim have been reported to interfere with hematopoiesis. Complete blood counts should be done frequently. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued. Bactrim should be given with caution to patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. Maintain adequate fluid intake. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Effects: Among the most common side effects are nausea, vomiting, rash, leukopenia and elevations in SGOT and creatinine.



ROCHE

Excellent clinical response in chronic urinary tract infections even with obstructive complications

A multiclinic, double-blind study* of response to a ten-day course of therapy in 471[†] patients with chronic urinary tract infections demonstrated the superiority of Bactrim. On the 10th day after initiation of therapy, 91.7% (of 168 patients) showed significant

bacteriological response to Bactrim, compared with 81.2% (of 144 patients) to trimethoprim and 64.5% (of 155 patients) to sulfamethoxazole. More than half of these patients had obstructive complications.

Excellent response maintained

Bactrim proved equally impressive in maintaining this bacteriological response. In the above study, after a ten-day course of therapy with Bactrim, 68.4% of patients with chronic urinary tract infections maintained response for up to 42 consecutive days, compared with

59.7% with trimethoprim and 44.4% with sulfamethoxazole. These results are particularly noteworthy considering the number of patients with obstructive complications — cases regarded as being notoriously difficult to treat.

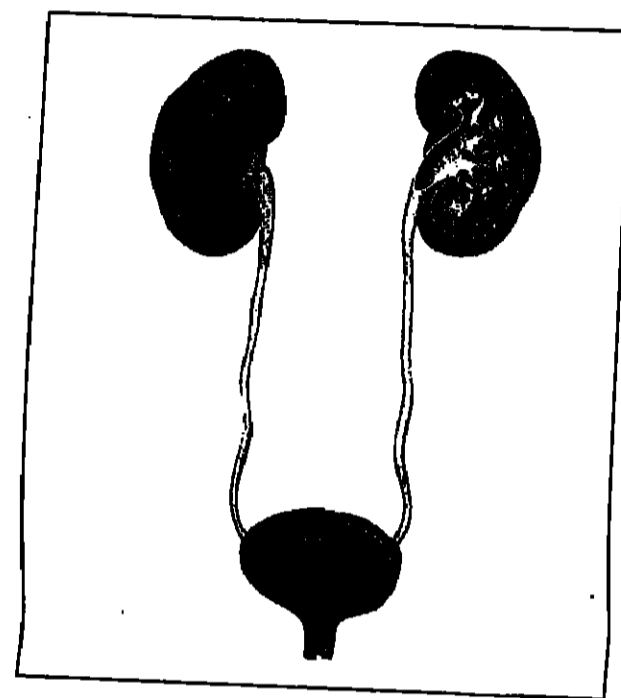
*Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110
[†]4 patients not available for evaluation at day 10.

new **BACTRIM**TM
Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

Before prescribing, please see complete product information on following page.

Rx
Bactrim
Tablets #40
Sig: Ti B.I.D.



- New type of antibacterial
- Unique dual mode of action
- Effective against susceptible urinary tract invaders: usually *E. coli*, *Klebsiella-Enterobacter*, *P. mirabilis*, and, less frequently, indole-positive proteus species
- No loading dose
- B.I.D. dosage
- Usual therapy: 10-14 days
- Excellent response in chronic urinary tract infections, primarily pyelonephritis, pyelitis and cystitis, due to susceptible organisms
- Impressive response in cases with urinary obstruction

Complete Product Information:

Description: Bactrim is a synthetic antibacterial combination product, available in scored light-green tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole.

Trimethoprim is 2,4-diamino-5-(3,4,5-trimethoxybenzyl) pyrimidine. It is a white to light yellow, odorless, bitter compound with a molecular weight of 290.3.

Sulfamethoxazole is N¹-(5-methyl-3-isoxazolyl) sulfanilamide. It is an almost white in color, odorless, tasteless compound with a molecular weight of 253.28.

Actions: Microbiology: Sulfamethoxazole inhibits bacterial synthesis of dihydrofolic acid by competing with para-aminobenzoic acid. Trimethoprim blocks the production of tetrahydrofolic acid from dihydrofolic acid by binding to and reversibly inhibiting the required enzyme, dihydrofolate reductase. Thus, Bactrim blocks two consecutive steps in the biosynthesis of nucleic acids and proteins essential to many bacteria.

In vitro studies have shown that bacterial resistance develops more slowly with Bactrim than with trimethoprim or sulfamethoxazole alone.

In vitro serial dilution tests have shown that the spectrum of antibacterial activity of Bactrim includes the common urinary tract pathogens with the exception of *Pseudomonas aeruginosa*. The following organisms are usually susceptible: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis* and indole-positive proteus species.

Representative Minimum Inhibitory Concentration Values for Bactrim-Susceptible Organisms (MIC—mcg/ml)				
Bacteria	Trimethoprim alone	Sulfamethoxazole alone	TMP/SMX (1:20) TMP	SMX
<i>Escherichia coli</i>	0.05-1.5	1.0-245	0.05-0.5	0.95-9.5
<i>Proteus spp</i>	0.5-5.0	7.35-300	0.05-1.5	0.95-28.5
<i>Proteus mirabilis</i>	0.5-1.5	7.35-30	0.05-0.15	0.95-2.85
<i>Klebsiella-Enterobacter</i>	0.15-5.0	0.735-245	0.05-1.5	0.95-28.5

Human Pharmacology: Bactrim is rapidly absorbed following oral administration. The blood levels of trimethoprim and sulfamethoxazole are similar to those achieved when each component is given alone. Peak blood levels for the individual components occur one to four hours after oral administration. The half-lives of sulfamethoxazole and trimethoprim, 10 and 16 hours respectively, are relatively the same, regardless of whether these compounds are administered as individual components or as Bactrim. Detectable amounts of trimethoprim and sulfamethoxazole are present in the blood 24 hours after drug administration. Free sulfamethoxazole and trimethoprim blood levels are proportionately dose-dependent. On repeated administration, the steady-state ratio of trimethoprim to sulfamethoxazole levels in the blood is about 1:20.

Sulfamethoxazole exists in the blood as free, conjugated and protein-bound forms; trimethoprim is present as free, protein-bound and metabolized forms. The free forms are considered to be the therapeutically active forms. Approximately 44 percent of trimethoprim and 70 percent of sulfamethoxazole are protein-bound in the blood. The presence of 10 mg percent sulfamethoxazole in plasma decreases the protein binding of trimethoprim to an insignificant degree; trimethoprim does not influence the protein binding of sulfamethoxazole.

Excretion of Bactrim is chiefly by the kidneys through both glomerular filtration and tubular secretion. Urine concentrations of both sulfamethoxazole and trimethoprim are considerably higher than are the concentrations in the blood. When administered together as in Bactrim, neither sulfamethoxazole nor trimethoprim affects the urinary excretion pattern of the other.

Indications: Chronic urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, and, less frequently, indole-positive proteus species).

Important note: Currently, the increasing frequency of resistant organisms is a limitation of the usefulness of all antibacterial agents, especially in the treatment of chronic and recurrent urinary tract infections.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides. Pregnancy and during the nursing period (see Reproduction Studies).

Warnings: Deaths associated with the administration of sulfonamides have been reported from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias. Experience with trimethoprim alone is much more limited, but it has been reported to interfere with hematopoiesis in occasional patients. In elderly patients concurrently receiving certain diuretics, primarily thiazides, an increased incidence of thrombocytopenia with purpura has been reported.

The presence of clinical signs such as sore throat,

fever, pallor, purpura or jaundice may be early indications of serious blood disorders. Complete blood counts should be done frequently in patients receiving Bactrim. If a significant reduction in the count of any formed blood element is noted, Bactrim should be discontinued. At the present time, there is insufficient clinical information on the use of Bactrim in infants and children under 12 years of age to recommend its use.

Precautions: Bactrim should be given with caution to patients with impaired renal or hepatic function, to those with possible folate deficiency and to those with severe allergy or bronchial asthma. In glucose-6-phosphate dehydrogenase-deficient individuals, hemolysis may occur. This reaction is frequently dose-related. Adequate fluid intake must be maintained in order to prevent crystalluria and stone formation. Urinalyses with careful microscopic examination and renal function tests should be performed during therapy, particularly for those patients with impaired renal function.

Adverse Reactions: For completeness, all major reactions to sulfonamides and to trimethoprim are included below, even though they may not have been reported with Bactrim.

Blood dyscrasias: Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoproliferative anemia and methemoglobinemia.

Allergic reactions: Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis.

Gastrointestinal reactions: Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis.

C.N.S. reactions: Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, dizziness, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness.

Miscellaneous reactions: Drug fever, chills, and toxic nephrosis with oliguria and anuria. Pericarditis nodosa and L.E. phenomenon have occurred.

The sulfonamides bear certain chemical similarities to some goitrogens, diuretics (acetazolamide and the thiazides) and oral hypoglycemic agents. Goiter production, diuresis and hypoglycemia have occurred rarely in patients receiving sulfonamides. Cross-sensitivity may exist with these agents. Rats appear to be especially susceptible to the goitrogenic effects of sulfonamides, and long-term administration has produced thyroid malignancies in the species.

Dosage and Administration: Not recommended for use in children under 12 years of age. The usual adult dosage is two tablets every 12 hours for 10 to 14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	2 tablets every 24 hours
Below 15	Use not recommended

How Supplied: Tablets, containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 1000; Prescription Packs of 40, available singly and in trays of 10. Imprint on tablets: ROCHE 50.

Reproduction Studies: In rats, doses of 533 mg/kg sulfamethoxazole or 200 mg/kg trimethoprim produced teratological effects manifested mainly as cleft palates. The highest dose which did not cause cleft palates in rats was 512 mg/kg sulfamethoxazole or 192 mg/kg trimethoprim when administered separately. In two studies in rats, no teratology was observed when 512 mg/kg of sulfamethoxazole was used in combination with 128 mg/kg of trimethoprim. However, in one study, cleft palates were observed in one litter out of 9 when 355 mg/kg of sulfamethoxazole was used in combination with 88 mg/kg of trimethoprim.

In rabbits, trimethoprim administered by intubation from days 8 to 16 of pregnancy at dosages up to 500 mg/kg resulted in higher incidences of dead and resorbed fetuses, particularly at 500 mg/kg. However, there were no significant drug-related teratological effects.

new

BACTRIM

Each tablet contains 80 mg trimethoprim and 400 mg sulfamethoxazole.

for chronic urinary tract infections

ROCHE Roche Laboratories Division of Hoffmann-La Roche Inc. Nutley, N.J. 07110

Wednesday, October 3, 1973

MEDICAL TRIBUNE

9

Israel's President Sees His Nation as a Social Laboratory

The text of an interview with the President of Israel, Efraim Katzir, by Dr. Arthur M. Sackler, International Publisher of MEDICAL TRIBUNE, follows. President Katzir, a famous biophysicist and a member of the U.S. National Academy of Sciences, demonstrated the antibacterial activity of the polyamino acids in his scientific work.



PRESIDENT KATZIR

Q. How does it feel to make the transition from professor to president?

A. It is a change. I have moved from laboratory to people, whereas before, in my earlier work, I moved from people into the laboratory.

Q. Isn't Israel a social laboratory?

A. Yes. We are a small country. Our inertia is not as great as that of the big powers. Thus, we can try new things—some succeed, others fail, and when they do we can, if necessary, retreat. We are a social laboratory in that our people come from different countries—50 per cent of our population are now from Arabic and Asian countries. They come from different income levels; some are low, and many even come empty-handed. Although from some countries we receive illiterates, from the Soviet Union as high as 20 to 40 per cent of our immigrants may have had academic training. We are also a laboratory in that our social services are organized to meet their needs and in good measure we practice social medicine.

Q. Do you have a close relationship between government and scientists?

A. Yes. Think of the context of our relationship. Many of our political leaders have friendly relations with scientists and humanist scholars. Moreover, all have worked and fought together.

Q. Doesn't science the world over share a common language and share the same goals?

A. A common language, no doubt. Israeli and Russian scientists speak the same language. The scientific method enables scientists to judge social phenomena in a common manner and with similar reactions. But does science itself have idealism? Doesn't science rather seek to understand the phenomena of Nature? It may be that the function of science is not to improve but to seek to understand Nature. I say this because, as you know, scientists as individuals too often exhibit in their universities and institutions what I would call "imperialistic" tendencies—if a leading scientist has one laboratory, he commonly wants two; if a section has one department, it seeks two; science itself may either help mankind or it may cause harm. If we want to apply science better socially, then the study of natural science and technology must also encompass the study of economic effects, morals, social attitudes, and even psychology. Science requires the moral values and the sense of justice that are so deeply rooted in the Jewish tradition.

Q. When you say the function of science is to seek to understand Nature, you speak like a Claude Bernardian.

A. I am.

Q. Claude Bernard always differentiated between art and science. He felt that the artist created something that didn't exist, but the great scientist only revealed an aspect of Nature that was there but not revealed. Claude Bernard said that a contemporary poet characterized the personality of art and the impersonality of science in the words: "Art is myself; science is ourselves."

A. No. In this respect I don't agree. A great scientist is in some ways like Beethoven. He does create something. He creates a theory which may never have been reality itself but is superimposed on Nature. But the problems that Claude Bernard and biologists face are different from those of the physicist. The physicist seeks for nonspecific, general laws. The biologist faces a living organism which is very, very complicated even though it may be based on general laws; he seeks the organism's specific reaction to its environment—something difficult to define. If a man falls from a great height, a physicist can easily explain the rate of fall. The biologist or psychologist would have great

I think they are stronger than political and economic power and, above all, I think they are more in keeping with Jewish history.

Q. As a biophysicist, you speak of spiritual values?

A. Yes, indeed. I feel strongly about these. I don't want to sound unduly proud, but do not all scientists need the lessons of law and morals? Must not science know how and when to use the tools it makes possible? It is important that the scientist consider his responsibility about how the knowledge that science reveals is used.

Q. I have heard it said that most technological developments in the history of man have been based on, advanced by, or made possible by wars.

A. I don't agree. I served for three years as adviser to the Ministry of Defense. Very few basic discoveries have been initiated by war. Basic principles of science are discovered during peacetime. They are discovered not in enormous operations but by individuals or by small groups. The application and use of the basic principles of science may take place. Basic principles are not really advanced by wars. This was as true for the atomic bomb as it was for radar.

Q. Has Israel set a pattern or precedent in having scientists as heads of state?

A. True. Our presidents, from Weizmann on, have been either scientists or scholars. The traditional respect for all scholars is great here. Perhaps the Government administrators and politicians want a scholar or scientist because they believe we don't know much about politics, so we won't interfere and we won't "make trouble." Perhaps, as scholars we are a symbol, precious to the people of this nation.

Q. How does it feel to be such a symbol?

A. It is a great experience. Recently, at the Western Wall (the only remnant of the ancient temple), I addressed 40,000 people. It was most moving. I believe the reactions stem from the feeling that in Israel the President represents the sublimation of our tradition and hopes for the future. In this country, with our type of government and parliament, the presidency has few powers, such as pardoning of prisoners, and many obligations, such as presiding at diplomatic occasions and frequent attendance at symbolic and social functions. Some may be routine. Others are unexpectedly emotional.

Last month, at an induction of judges, one of the men wept uncontrollably through the ceremony. "Why?" I asked. He said, "I was a Russian partisan fighting behind the German lines. My life was always in balance. I never dreamt I'd last out the war. I was captured. I never dreamt I'd live. I was put in a concentration camp. I did not expect to survive. How could I have dreamt that I would survive the war, that a Jewish state would come into being, that I would be able to

reach it, that I would become a part of it, and that today I become a judge in Israel and have you, Israel's President, personally confer this honor on me?"

Q. Is this still a land of miracles?

A. Yes. **Q. How would you, from a governmental point of view, approach science?**

A. Basic science is not easy to direct. "Find a good man, give him facilities, and don't interfere," Weizmann used to say to the director of our scientific establishment, Weisgal, who was a writer, not a scientist. "Look, if you want to be of help, just don't interfere. Allow the scientist to do what he wants to. If a scientist is walking in the garden, for goodness' sake don't interfere. He may be getting an idea. If he is talking with a pretty girl, don't interfere. You don't know what ideas may be generating in his brain. Give them freedom, but don't give them too much money. Scientists don't use money; they burn it up. Therefore, administration is your responsibility. Ideas and the freedom to create is their responsibility."

Q. Is this true for all science?

A. No. On the other hand, when one comes to applied research, I think it must be carefully planned.

Q. Would you care to comment on either the hydrogen or atomic bomb?

A. Well, as Jews we feel very sensitive about the Atomic Age because so many of our people made it possible. Einstein, a Jew from Germany; Leo Szilard from Hungary; Lise Meitner from Austria; Teller originally from Hungary; and Oppenheimer from America.

Q. Was Enrico Fermi from Italy one of this group?

A. No. We jokingly said he was half so. Fermi was a Christian who left Italy. His wife was Jewish. One of his assistants in Rome, the late professor Racah, later served under me when I was an officer in the Haganah (the defense force).

Q. Can Israel, through science, help fulfill the Biblical dream of beating swords into plowshares?

A. Ah, look up, and on the ceiling of this presidential office, here it is written as in the Bible:

Nation shall not lift up sword against nation, neither shall they learn war any more.

This is the most sincere desire—a desire of all Jews. But, as has so often happened in our history, it is a question of life or death. All Jewish history has indicated that we have no choice but to have the military strength that prevents wars. We must be strong, but great strength must be matched by high moral standards.

Q. Would you like to make any concluding observation?

A. Yes, I believe that Israel and Jews have an enormous responsibility that the achievements of science be used for the advancement of all mankind.

Destruction of Phenylalanine May Cut Cancer Cell Growth

Medical Tribune Report

GALVESTON, TEX.—Investigators at the University of Texas Medical Branch have found that phenylalanine ammonia-lyase depletes leukemic cancer cells of a nutrient, Dr. Creed Abell, head of a cancer research team here, reports.

"We have found, in treating mice for acute lymphoblastic leukemia, that PAL reduces or destroys an essential amino acid, phenylalanine, in the blood, and without this nutrient cancer cells die," Dr. Abell said.

However, because PAL also depletes normal cells of life-giving phenylalanine, it is used in conjunction with a substitute amino acid in treating the tumorous mice. "The substitute, phenylpyruvate, is unique because the leukemic cancer cells can not metabolize it, while normal cells can," he said.

Dr. Abell, Professor of Biochemistry in the Department of Human Biologic Chemistry and Genetics at U.T.M.B., said that

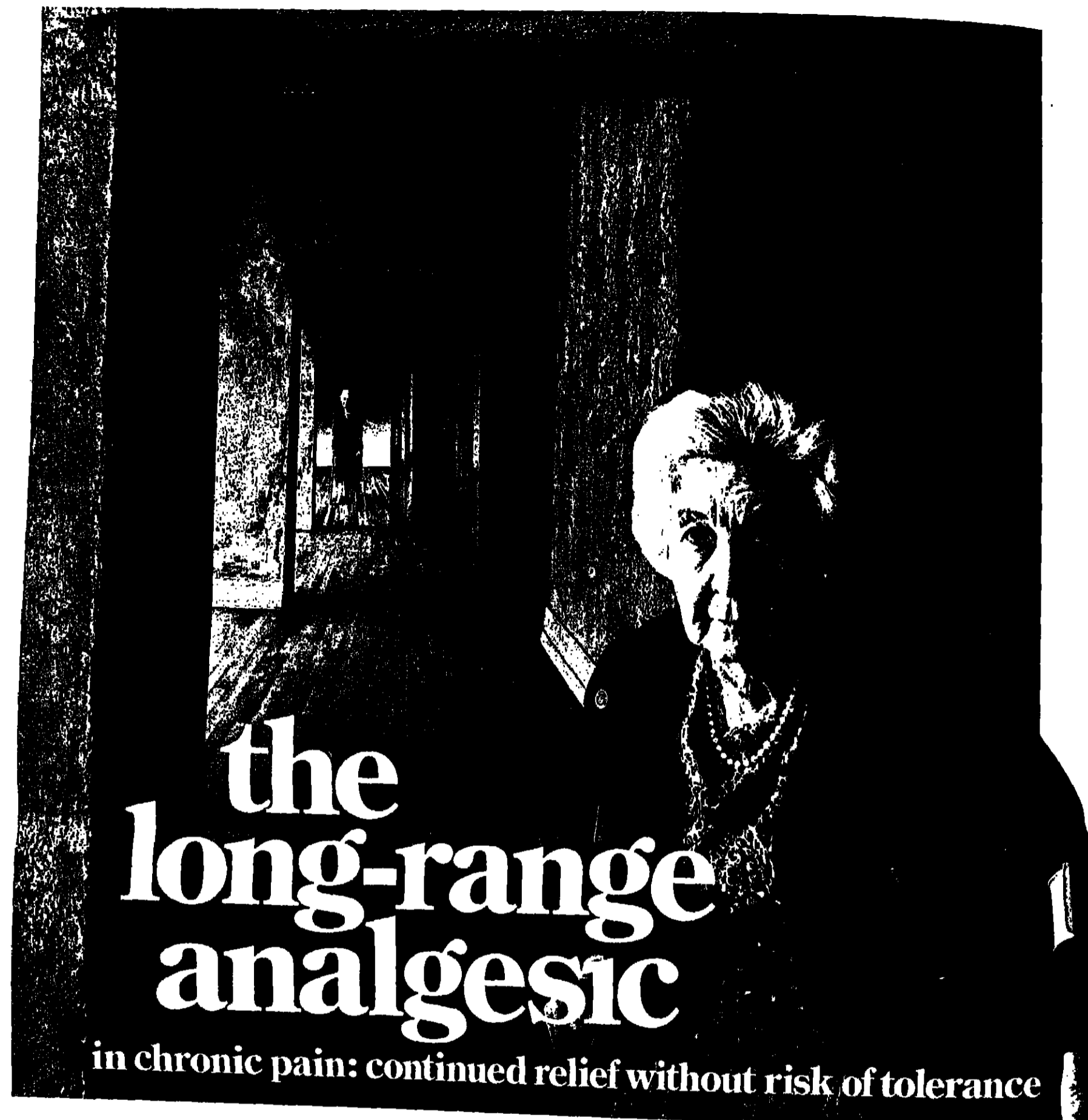
in the latest test series six of 14 leukemic mice were cured—or 43 per cent. Of those that died, all had extended life spans of five to six days more than would have been achieved in non-PAL-treated mice.

New Device Gives Details About Blood Coagulation

Medical Tribune Report

ATHENS, GA.—A device that gives detailed information about blood coagulation, including the time for a clot to form, has been developed by two chemists at the University of Georgia.

Peter W. Carr, Ph.D., Assistant Professor of Chemistry, and William D. Bostick, a research assistant, the developers, said their device detects almost the exact instant of coagulation and that it works on both clear and turbid samples, monitors the temperature of the sample throughout the test, and provides a record of all steps in the test.



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in chronic pain: continued relief without risk of tolerance

Though Talwin® Tablets can be compared to codeine in analgesic efficacy, Talwin is not subject to narcotic controls. For patients who require potent analgesia for prolonged periods, Talwin can provide consistent, long-range relief, with fewer of the consequences you've come to expect with narcotic analgesics.

- Comparable to codeine in analgesic efficacy: one 50 mg. Talwin Tablet appears equivalent in analgesic effect to 60 mg. (1 gr.) of codeine. Onset of significant analgesia usually occurs within 15 to 30 minutes. Analgesia is usually maintained for 3 hours or longer.
- Tolerance not a problem: tolerance to the analgesic effect of Talwin Tablets has not been reported, and no significant changes in clinical laboratory parameters attributable to the drug have been reported.
- Dependence rarely a problem: during three years of wide clinical use, only a few cases of dependence have been reported. In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.
- Not subject to narcotic controls: convenient to prescribe—day or night—even by phone.
- Generally well tolerated by most patients: infrequently cause decrease in blood pressure or tachycardia; rarely cause respiratory depression or urinary retention; seldom cause diarrhea or constipation. If dizziness, lightheadedness, nausea or vomiting are encountered, these effects may decrease or disappear after the first few doses. (See next page of this advertisement for a complete discussion of Adverse Reactions and a Brief Summary of other Prescribing Information.)

50mg. Tablets **Talwin®**
brand of
pentazocine
(as hydrochloride)
in moderate to severe pain

in chronic pain: continued relief without risk of tolerance

Talwin® Tablets brand of pentazocine (as hydrochloride)
Analgesic for Oral Use—Brief Summary

Indications: For the relief of moderate to severe pain.

Contraindication: Talwin should not be administered to patients who are hypersensitive to it.

Warnings: Drug Dependence. There have been instances of psychological and physical dependence on parenteral Talwin in patients with a history of drug abuse and, rarely, in patients without such a history. Abrupt discontinuance following the extended use of parenteral Talwin has resulted in withdrawal symptoms. There have been a few reports of dependence and of withdrawal symptoms with orally administered Talwin. Patients with a history of drug dependence should be under close supervision while receiving Talwin orally.

In prescribing Talwin for chronic use, the physician should take precautions to avoid increases in dose by the patient and to prevent the use of the drug in anticipation of pain rather than for the relief of pain.

Head Injury and Increased Intracranial Pressure. The respiratory depressant effects of Talwin and its potential for elevating cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Furthermore, Talwin can produce effects which may obscure the clinical course of patients with head injuries. In such patients, Talwin must be used with extreme caution and only if its use is deemed essential.

Usage in Pregnancy. Safe use of Talwin during pregnancy (other than labor) has not been established. Animal reproduction studies have not demonstrated teratogenic or embryotoxic effects. However, Talwin should be administered to pregnant patients (other than labor) only when, in the judgment of the physician, the potential benefits outweigh the possible hazards. Patients receiving Talwin during labor have experienced no adverse effects other than those that occur with commonly used analgesics. Talwin should be used with caution in women delivering premature infants.

Acute CNS Manifestations. Patients receiving therapeutic doses of Talwin have experienced, in rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours. The mechanism of this reaction is not known. Such patients should be very closely observed and vital signs checked. If the drug is reinstituted it should be done with caution since the acute CNS manifestations may recur.

Usage in Children. Because clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended.

Ambulatory Patients. Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

Precautions: Certain Respiratory Conditions. Although respiratory depression has rarely been reported after oral administration of Talwin, the drug should be administered with caution to patients with respiratory depression from any cause, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

Impaired Renal or Hepatic Function. Decreased metabolism of the drug by the liver in extensive liver disease may predispose to accentuation of side effects. Although laboratory tests have not indicated that Talwin causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment.

Myocardial Infarction. As with all drugs, Talwin should be used with caution in patients with myocardial infarction who have nausea or vomiting.

Biliary Surgery. Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

Patients Receiving Narcotics. Talwin is a mild narcotic antagonist. Some patients previously given narcotics, including methadone for the daily treatment of narcotic dependence, have experienced mild withdrawal symptoms after receiving Talwin.

CNS Effect. Caution should be used when Talwin is administered to patients prone to seizures; seizures have occurred in a few such patients in association with the use of Talwin although no cause and effect relationship has been established.

Adverse Reactions: Reactions reported after oral administration of Talwin include gastrointestinal: nausea, vomiting; infrequently constipation; and rarely abdominal distress, anorexia, diarrhea. CNS effects: dizziness, lightheadedness, sedation, euphoria, headache; infrequently weakness, disturbed dreams, insomnia, syncope, visual blurring and focusing difficulty, hallucinations (see Acute CNS Manifestations under WARNINGS); and rarely tremor, irritability, excitement, tinnitus. Autonomic: sweating; infrequently flushing; and rarely chills. Allergic: infrequently rash; and rarely urticaria, edema of the face. Cardiovascular: infrequently decrease in blood pressure, tachycardia. Other: rarely respiratory depression, urinary retention.

Dosage and Administration: Adults. The usual initial adult dose is 1 tablet (50 mg.) every three or four hours. This may be increased to 2 tablets (100 mg.) when needed. Total daily dosage should not exceed 600 mg.

When antiinflammatory or antipyretic effects are desired in addition to analgesia, aspirin can be administered concomitantly with Talwin.

Children Under 12 Years of Age. Since clinical experience in children under 12 years of age is limited, administration of Talwin in this age group is not recommended for prolonged periods. Patients with chronic pain who have received Talwin orally for prolonged periods have not experienced withdrawal symptoms even when administration was abruptly discontinued (see WARNINGS). No tolerance to the analgesic effect has been observed. Laboratory tests of blood and urine and of liver and kidney function have revealed no significant abnormalities after prolonged administration of Talwin.

Overdosage Manifestations. Clinical experience with Talwin overdosage has been insufficient to define the signs of this condition.

Treatment. Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. Although nalorphine and levallorphan are not effective antidotes for respiratory depression due to overdosage or unusual sensitivity to Talwin, parenteral naloxone (Narcan®, available through Endo Laboratories) is a specific and effective antagonist.

Talwin is not subject to narcotic controls.

How Supplied: Tablets, peach color, scored. Each tablet contains Talwin (brand of pentazocine) as hydrochloride equivalent to 50 mg. base. Bottles of 100.

Winthrop Laboratories, New York, N.Y. 10016 **Winthrop**

50mg. Tablets **Talwin®**
brand of
pentazocine
(as hydrochloride)
in moderate to severe pain

One Man...and Medicine

ARTHUR M. SACKLER, M.D.,
International Publisher, Medical Tribune



The Chariots of the Gods—and the 747

IT WAS A HOT SUN. There was no shade as we drove through Piraeus on our way to Athens. Offshore, ship after ship of the American fleet, cruisers and tankers and submarines, rode at anchor near where once the Argonauts embarked. One couldn't help thinking "Plus ça change, plus c'est la même chose." For our astronauts, the Golden Fleece was the moon. Remains the same, did I say? No; man is never quite the same. In his striving "to be," there seems to have been a change, an escalation—in quantitative inflation.

I had looked forward to coming back to Piraeus. It was changed. A decade ago, I attended a medical meeting in Athens and paid my tribute at the sites of so many of man's achievements. Changed it was, but not for the better. Cars and Coca-Cola signs, neon lights, and plastic bedeck the streets of Piraeus and Athens. They are mixed blessings, these "achievements" of technology.

I had just spent a fortnight in the Middle East, across the "wine-red sea" of Homer, when I thought I could adjust my schedule to spend a day in the land of Pericles and Praxiteles. I had just shared with my daughter Denise, who is 18 and beautiful and vividly alive, the shrines of that early crossroads of the world which was the source of three faiths. And so, from the lands which nurtured so much religious faith and from an interview with the head of state, we were transported by 747 jet to another land of shrines, shrines to the intellect of man and to his aesthetics.

Of course we climbed the Acropolis and marveled at the Parthenon. We checked in at the Acropolis Museum; its director, Nicolas Platon, was away at a "dig." On our last visit I had missed him at his dig at Kata Zacro (on Crete) and found him here in Athens. This time it was the other way 'round. On to the National Archaeological Museum. There are several things there I particularly wanted to share with Denise—the beautiful archaic sculpture, the marbles of Praxiteles. I wanted to refresh and enlarge my exposure to the cyclopic masterpieces, to see with new eyes the great bronzes of Greece; the three heroic-sized figures that we had seen a decade ago, when they had just been found in a sewer excavation in Piraeus. What wonders of beauty. And then, of course, the treasures of Schliemann.

"Tavernas" Now Touristy

With the cool of dusk, we walked through the Plaka. Its tavernas, once so typically Athenian, are now touristy. We planned a table at a "native" taverna, where the grape leaves and lamb dishes can be savored to the music of three guitarists, who enjoy playing our favorite songs of Crete. Then on to the Odeon of Herodes Atticus. That wealthy banker had built it in A.D. 161. Carved into the rocks on the southern slope of the Acropolis, this 5,000-seat restored amphitheater provides a magnificent setting for festivals of music and drama. An almost unbroken tradition of over 2,000 years continues. It was in Athens that Thespis sought the prizes in state-sponsored competitions more than two and a half millenniums ago with the same zeal but perhaps less cunning than the Thespians of our day compete for an Oscar. Here, works of the early dramatists still challenge actors and audiences with their deathless plots, with their poetic and choreographic rhythms. Western dramatists have wandered from the origins of European drama, from the medieval Mass and Easter services. Attic drama still relates to its roots in religious rites. The dramatists—Aeschylus, Sophocles, Euripides—educated three generations of Athenians with their unique blend of dramatic recitation, music, and dance.

Before 5,000 silent, almost reverent spectators hanging on each phrase, with each whisper clearly audible in the rear rows of the amphitheater, under the darkening cool night sky, all were transported back in time.

Modern science has displaced much of the beauties of man's handicraft with a tasteless, disposable plastic "civilization." That same science, paradoxically, projects men into the realms of the gods—through the heavens above and under the seas below. Man now flies through the skies with a speed and comfort unmatched by the fabulous golden chariots of the gods of Greece. And so, in just hours, we were carried back not only in space but in time to worship at the temples of Greece, to see their gods, to revel in the aesthetic beauty of bronze and stone, to share the timeless truths of the tragedies of Greece.

In many ways, the Greeks set precedents for the Western stage. The ancient Greek lyrical poets fused in their art-poetry, music, rhythmic action. They were dramatists and poets, musicians and pantomimists, choreographers and directors as well—a combination, if you will, of Shakespeare and Mozart, of Verdi and Ballanchine. The Greek dramatists lived not just in a "welfare state" but at a time of great patrons of the arts. In our society, science gets the lion's share of patronage; the leavings go to painting, and some gleanings for sculpture and music. In ancient Greece, drama ruled the roost.

"Was" vs "Should Be"

Euripides was an enthusiast who gave full play to his thoughts and emotions. His fellow dramatist, Sophocles, didn't hesitate to point the difference between the two. He, Euripides, depicted human nature "as it was." Sophocles recorded it "as it should be" and how it reacts under the stresses and strains of the fate that is inevitable. Sophocles and Shakespeare had more in common than just the writing of plays and poems, directing, and acting. As idealized as some of the aspects of Sophocles' characters are, his delineation of personality was lifelike, true to type, consistent, and, above all, seeking after justice and speaking for nobility. He differs from Shakespeare in that Sophocles banned the low, the petty, and the ridiculous, the bare egotism, the puerile, and the malignant, which Shakespeare utilized to offset the tragic nobility of both character and plot. We must speak again of Sophocles when on another occasion we return to Thebes, as Velikovsky did in his *Oedipus and Akhnaton*.

This night in Athens was to be devoted to *Medea* in operatic form, the one written by Cherubini, Italian-born Parisian, master of counterpoint. The opera *Medea* was first presented in 1797. After an interval of 100 years it reappeared again at La Scala and then, over 60 years later, was triumphantly presented in Greece. It is the tragedy of Jason, he of the Golden Fleece. Betrothed to the daughter of the King of Corinth, Jason plans to leave Medea, who had borne him two sons. The tragic course is classically inevitable—the punishment of man's hubris. Medea poisons Jason's bride with her wedding presents, kills her own children, and, in the equally classic *deus ex machina*, is taken to the gods in a chariot pulled by dragons.

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CLB

Doctors' Debate

MEDICAL TRIBUNE frequently receives extensive and well-documented communications from physicians on current subjects of controversy or those of great current medical interest. We invite contributions in these areas for presentation in this new feature.

A DuVal Controversy

In the August 15 issue of MEDICAL TRIBUNE, page 1, Dr. Merlin K. DuVal, vice-president for health sciences, University of Arizona, and former assistant secretary of HEW, said that the public is dissatisfied with the "inequitable" distribution of health services, and called on the medical profession to regulate the location and specialties of its members.

Dear Dr. DuVal:

If the "direct quotes" which appeared on August 15 in MEDICAL TRIBUNE are correct, one would conclude that your Government inoculation has dedicated you to the destruction of freedom to practice wherever a doctor wishes to in the United States of America.

Why are we different than any other American citizen? Why must we be assigned to an area or perhaps by a practice, or have to petition the Government or a medical society for the privilege of living where we wish? This has been proved to be a failure in Austria, as well as several other European countries.

Why must we deny people of the privilege to fall? This is unique in America, and it is one of the most important privileges we still have. Freedom built this country, and its continued infringement by the Government will destroy it—just as it destroyed every other previous topmost world civilization. I will be glad to accept this as a concept if every other citizen of the United States accepts the concept that the Government may tell him where to live and what to do.

I know that this is a difficult problem—getting doctors to every area where people live—but the loss of freedom, which must of necessity follow such action, would be a terrible price to pay.

JOHN M. RUMSEY, M.D.
San Diego, Calif.

Dear Dr. DuVal:

I read with interest, the article in the August 15 MEDICAL TRIBUNE—that there is "inequitable distribution of health services" and that "professional preference has been allowed to go too far"—and your call for "the medical profession to regulate the location and specialties of its members." I agree that "as long as each physician has free choice—he will almost invariably choose his location and the type of services he will render to meet his own needs." His needs do, of course, include satisfactory medical facilities, a satisfactory community, or feasible proximity to one that will, reasonably and satisfactorily, supply a consumer need for his services that will efficiently make full utilization of his talents and services, that will meet his own needs for continuing education, continuing professional associations, mental stimulation in general, and a satisfactory physical, educational, and moral and safe climate for his family and the financial rewards that will afford these things to him.

Most physicians, with these things in mind and with our own prime personal knowledge of our personal individual needs and capabilities, have by free choice chosen practice sites where we are needed, where our talents will be best utilized, with satisfactory environments for our families, and with adequate financial rewards. A large majority of us are less than completely satisfied and are often markedly dissatisfied with the amount of time we have with our patients, with the loss of the old-time doctor-patient relationship, with the environment for professional education, with the time available for our families, and with the time and opportunity for association with our professional peers.

I had thought that perhaps you were a

Ph.D. I am pleased to learn that you are an M.D. I know that you will want to do all that you can to prevent the medical profession from becoming "fat, self-satisfied, and even self-indulgent." I know that you will want to do your individual part. I have a letter from Williams Hospital, Williams, Ariz. They are desperately in need of physicians. I know that, out of your concern for them and their needs and the need for the medical profession to redistribute its members, you will be glad to offer your professional services to this community and redistribute the medical population in your own state to a deserving community in your own state. This sounds like a fine community, with good medical facilities.

If you feel, for some reason, that Williams, Ariz., would not fit your own personal needs, though I cannot imagine your allowing your own personal needs to enter into your decision, I know of many places desperately needing M.D.s that would welcome you. As you yourself

know, there are many such locations in Alabama, Mississippi, and the Bronx, but most of us in the medical profession know many, many more also that would be much closer to your present location and be more convenient for you to relocate to; though, of course, you realize that you should not consider your own personal convenience, I will be happy to supply you with listings of "physicians wanted."

CHARLES A. CASHMAN, M.D.
Calxico, Calif.

Editor, MEDICAL TRIBUNE:

Dr. Merlin K. DuVal asserts that the medical profession should order its members into certain locations and specialties.

I wonder how long it will be before the medical profession will cense to deprive its members of basic inalienable rights given every American citizen simply because "if the profession doesn't do it, the government will." How many plumbers, electricians, lawyers, economists, or garbage collectors would allow anyone to tell them where they must live and in what specialty they must practice their trade or profession? The law of supply and demand is the surest method of determining how many specialists should be in a given specialty and geographic area.

If the Government wishes to staff hospitals or clinics in underprivileged areas of our country, the Government should set up a program for subsidizing the medical education of individuals who will accept, as part of this support, the obligation to practice in certain areas and in certain specialties for a prescribed length of time. Those of us who have paid for our own medical education do not feel that we wish to abrogate our constitutional rights simply because a bureaucratic wishes for a different distribution of physicians.

ROLAND C. KREPS, JR., M.D.
Merced, Calif.

Editor, MEDICAL TRIBUNE:

Where does Dr. DuVal get the unmitigated gall to tell people where and when they shall live and work under what circumstances they shall pursue "life, liberty, and the pursuit of happiness," as guaranteed in the Bill of Rights?

Dr. DuVal shows the typical traits of a petty commissar, and I think he ought to go to see his most accessible psychiatrist. G. THOMAS SAMARTINO, M.D.
South Miami, Fla.

Doing little things better



caring better for his basic needs, less confused in his thinking; no great accomplishment for most people, but a significant advance for the patient with cerebral arteriosclerosis*

Hydergine®

SUBLINGUAL TABLETS containing 0.167 mg. dihydroergocornine methanesulfonate, 0.167 mg. dihydroergocristine methanesulfonate, and 0.167 mg. dihydroergokryptine methanesulfonate

helps patients with cerebral arteriosclerosis do little things better

The usual dosage is four to six sublingual tablets daily. The patient's improvement with Hydergine is usually demonstrated in four to six weeks. Some nasal stuffiness due to adrenergic blockade, transient nausea or gastric disturbances have been reported with high dosages.

*Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indication as follows:
"Possibly" effective: The treatment of cerebral arteriosclerosis and dizziness, mood changes, nocturnal cramps, and paresthesias in the aged.
Final classification of the less-than-effective indication requires further investigation.

SANDOZ PHARMACEUTICALS, EAST HANOVER, N.J. 07936

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Cancer, Cyclamates, and Lobbies

WHEN A FEW RATS were reported to have developed bladder cancers as a result of some confusing studies with cyclamates, MEDICAL TRIBUNE raised a number of cautions about both the findings and the ensuing hysteria. The developments that followed are interesting and instructive. Cyclamates were banned from general use as sweetening agents. Saccharine, which was not, was next reported to be associated with malignancies in experimental animals. More important, Nobel laureate Denis P. Burkitt observed in man that on an epidemiologic basis intestinal malignancies and other intestinal disorders were related to diets high in refined carbohydrates.

The distinguished British journal *Nature* made some sour editorial comments about the "farical progress" of the cyclamate bandwagon and questioned whether "scientific advisers or the politicians who manipulated them look the more ridiculous." The journal emphasized that the evidence of the cancer potential of cyclamate was "about as solid as candy floss."

Throughout this period of time there

were rather nasty rumors to the effect that the publicity and pressure for removal of the cyclamates was a result of activities of "the sugar lobby." More recently, a study in West Germany on 832 rats receiving cyclamates revealed bladder cancer in only one, and that was unrelated to dosage. The investigator concluded that the tumor was unrelated to cyclamates. Preliminary results from the University of Nebraska indicate no adverse effects from the feeding of cyclamates to 360 golden hamsters. Malignancies in man have yet to be linked to cyclamates.

In view of Burkitt's observations, one wonders how many intestinal tract malignancies were caused by the FDA's action in removing the cyclamates. There is one issue in this matter of the cyclamates which is subject to rather simpler determination than the carcinogenicity of cyclamates or the number of malignancies in man consequent upon their regulatory removal. What role, if any, did the sugar lobby play in the cyclamate fiasco?

A.M.S.

Genetic Engineering

ABOUT 24 YEARS AGO Edwin Chargaff discovered the principle of base pairing of nucleic acids. Thus, in DNA, adenine pairs with thymine, guanine with cytosine. It is this principle that made possible the elucidation of the double helix of DNA by Watson and Crick and, in 1967, permitted the synthesis of a biologically active single stranded DNA from a natural virus by Arthur Kornberg and his colleagues.

In 1970 Har Gobind Khorana and his colleagues reported the synthesis of the double-stranded gene that directs the formation of alanine transfer RNA in the yeast cell. At the time it was known that Professor Khorana was also engaged in the synthesis of a second gene that directs the formation of tyrosine transfer RNA in *Esch. coli*. That accomplishment was recently reported at the national meeting of the American Chemical Society (MEDICAL TRIBUNE, September 19). It is likely that before long Professor Khorana will announce the synthesis of the additional gene structures controlling its "start and stop" function.

There is no doubt that the work of

Kornberg and Khorana—and others—is ultimately directed at repairing defective genes in man, once a mechanism will have been worked out for delivering the corrective DNA to a patient's cells, as is conceivable with the use of a benign infective virus bearing the missing coding information. Marshall W. Nirenberg was one of the joint recipients of the Nobel Prize for working out the genetic code for amino acid instructions in protein synthesis. In 1967 he wrote, "My guess is that cells will be programmed with synthetic messages within 25 years."

Professor Chargaff takes a very dim view of all this and in a recent article referred to it as what is "vulgarily called genetic engineering." He added, "It is not so much I fear the success—there won't be any—but rather that such an attempt, windy and hopeless and barbaric as it may be, lifts our sciences and all of us to an ever-higher level of moral entropy."

The signs, however, indicate that genetic engineering will come into being. And, as has been stated here before, ethical problems will arise that should be evaluated now.

The Returning Tourist

CLINICAL QUOTE: "Some of the diseases American tourists may encounter abroad and bring back are amebiasis, giardiasis, roundworm or tapeworm infections, bacillary dysentery, and rarely typhoid fever, tropical sprue, lymphogranuloma venereum, hydatid disease, typhoid or brucella spondylitis, or madurocyclos. The incidence of these diseases is endemic areas, especially the

tropics, where American tourists visit, is alarmingly high, but has been quite low among tourists themselves, with the exception of some of the water- or food-borne diseases such as amebiasis, giardiasis, and bacillary dysentery.... American physicians can expect to see an increasing number of some of these diseases in their radiological or clinical practice." (Medical X-Ray Forum; see page 1.)



"It doesn't apply to me. I'm going into a freezerium."

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A Pox on Vaccination

Dr. Andre J. Lebrun [Letters to Tribune, August 1] expresses his hope that "world-wide smallpox vaccination will have been achieved." Whether or not routine smallpox vaccination should be continued in the U.S.A. is a moot argument; the question has been answered and the recommendations are known.

As of August 29, only five countries in the world reported cases of smallpox. Intensive efforts are under way to eradicate the disease in these few remaining foci. It can be reasonably expected that these efforts will be successful within the decade, as they have been in recent years in the western hemisphere and in West Africa.

Dr. Lebrun must be aware that world-wide vaccination is impracticable, whereas world-wide eradication is within sight. I firmly believe that he meant to say "world-wide smallpox eradication." I also believe this should be made clear to those who still advocate routine smallpox vaccination in this country, which is for all but those at high risk of infection unnecessary, expensive, and potentially dangerous.

RUDOLF G. WANNER, M.D.
Medical Training Officer
Center for Disease Control
Atlanta, Ga.

M.D. as Political Animal

For a long time I have admired your editorial page for its well-phrased, concise manner of reporting medical advances; however, I was appalled at your lead editorial addressed to "Mr. President" in the September 5 issue.

I happen to be one of the approximately 20 per cent of American physicians who voted against Mr. Nixon in the last election. You chided Mr. Nixon for his failure to include, among the situations requiring confidentiality, the one existing between physician and patient. "Its omission is inadmissible," you said.

Mr. Editor, how come you omitted to say anything about Watergate, White House "horrors," financial deceptions, political espionage and sabotage, illegal Cambodian bombing, White House "Enemies list," impounding of congressionally appropriated funds, etc., *ad nauseam*?

You also rebuked him for breaking his pledge and permitting HEW to promote a "dramatic escalation of interference in the area of medical practice."

Mr. Editor, have we as physicians become so insulated that we think of ourselves as physicians first, foremost, and always? Are we not made of the same stuff as other citizens of this country? When we are pricked, do we not bleed? Dare we not voice our displeasure over the serious abuses of government power,

as well as over criminal offenses Mr. Nixon's Administration is charged with? Or are we to speak out only when medicine's self-interest is served?

A more appropriate and timely editorial by MEDICAL TRIBUNE would have been a consensus psychoanalysis of the President. As he sees it, the world, the Congress, courts, and press are all against him. In his latest press conference he blamed Congress for high prices and inflation; blamed the press rather than the burglars and spies for his Watergate troubles; told the Supreme Court that he would obey only a "definitive" judgment on the Watergate tapes, without explaining what "definitive" meant, or why he alone of all Americans had the right to pass judgment on Supreme Court decisions. Does this sound paranoid, egomaniacal, and dictatorial to you? Me too.

SOL BROWDY, M.D.
Trenton, N.J.

Variety Is the Spice

I read with great delight the editorial on "The Endangered Species." I had one of my interns read it aloud to the entire group making rounds. I believe they got more out of your editorial than they did out of rounds that morning.

WILLIAM A. LEFF, M.D.
East Orange, N.J.

Significant Sem-Antics

"Dr. Fox's" flashy lecture [on gobbledygook] at U.S.C. (MEDICAL TRIBUNE, August 22) has significant implications. Such gullibility, uncritical analysis, or stupidity amongst a group of 55 "professionals" is shocking. Showmanship and style carry more weight than content. No wonder an actor can rise to leadership in politics, government, or any field he chooses.

If professionals are taken in by such tactics, what must be happening to the American public, bombarded en masse daily for hours by skilled actors via the aptly named "boob tube"? Lincoln was wrong. Today, all of the people can be fooled all of the time—at least on the subject of "mathematical game theory as applied to physician education."

The astute U.S.C. investigators made a classic observation. How deeply have the ranks of medicine and science been infiltrated by undetected "actors," spreading phoniness not only in the lecture room but in the literature? Medical students and physicians are not such sophisticated and observing professionals that they can unfailingly spot a phony. Now is the time to take a long, close look at medical educators and literature and separate the real from the "put-ons." More of the latter may be around than we suspect.

HERBERT L. JOSEPH, M.D.
Vallejo, Calif.

Texas TB Plan Provides Service to Remote Counties



Equipment used in the clinics must be easily transported. Carrying records, eye charts, and other equipment, the nurse often resembles a traveling medicine man. In many localities the nurses are the only providers of health care services.



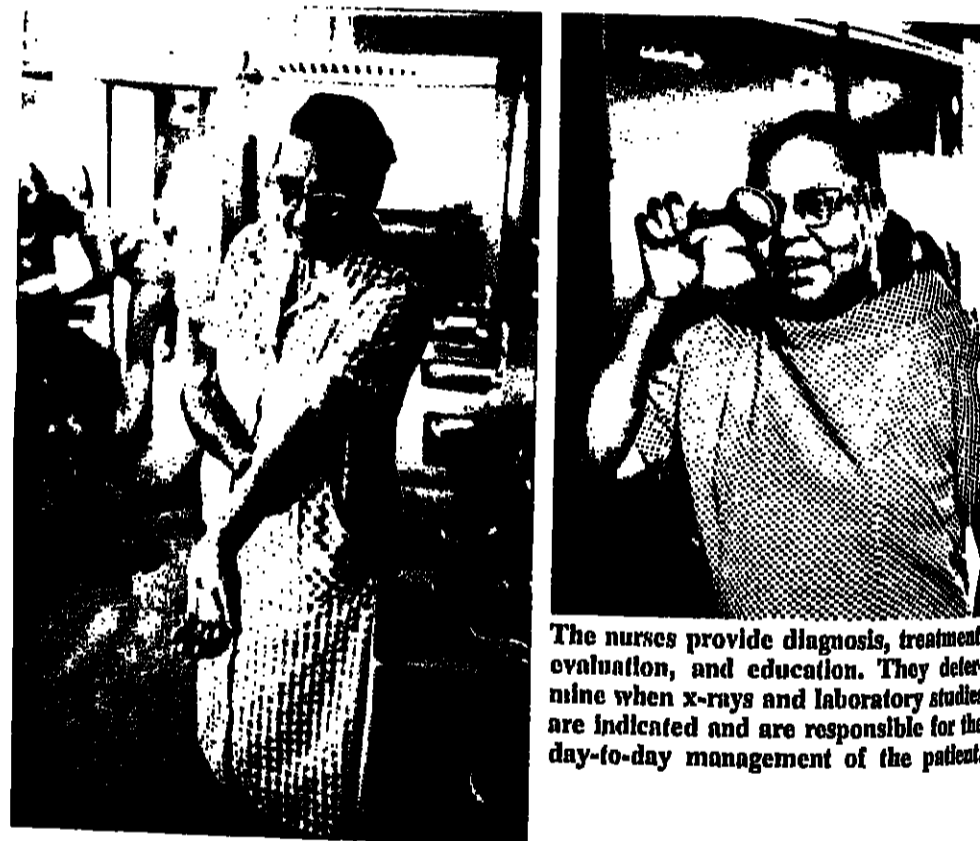
Clinics may be held in community centers, churches, schools, post offices, "washaterias," parks, or any other facility that is available.



THE TUBERCULOSIS Control Program in Texas provides service to residents of 254 counties covering 275,416 square miles. Twenty-one of these counties have no physicians, so their population of 11,420,587 is served by 130 TB-control field nurses. In order to assure supervision and care for the 15,195 home cases and more than 16,000 patients who received chemoprophylaxis last year, the nurses often travel 100-150 miles to conduct clinics in remote areas where facilities are poor to nonexistent.



"If you haven't held a clinic in a 'washateria' with the washing machines jumping up and down at you, you haven't lived," says Ella Herring, director of nursing.



The nurses provide diagnosis, treatment, evaluation, and education. They determine when x-rays and laboratory studies are indicated and are responsible for the day-to-day management of the patient.



The response of the patients to the clinic with a nurse in attendance has been good. They feel they can sit and talk with the nurse without the interruption of the children or other distractions and that the time she is spending with them is exclusively theirs. In addition, in many rural areas it gives people an opportunity to "go someplace" and visit with their friends.

Diabetes Studies of East, West Compared

Medical Tribune World Service

BRUSSELS—Striking differences between East and West in incidence and complications of diabetes were pointed up by epidemiologists at the eighth Diabetes Congress here.

They reported that:

- Sex ratios of diabetes are reversed in certain parts of India and Japan, as compared with Western countries. There is a male:female ratio of 3:1 in a rural population and of 2:1 in an urban population in India.

- A "crude comparison" of physical activity and diabetes, made in the same Indian study, showed physical inactivity scoring more as a diabetogenic factor than a high caloric intake.

- While the small-vessel disease rates are not greatly different, apparently the large-vessel disease rate among diabetics is several times higher in the Western world than in the underdeveloped countries.

Dr. Kelly M. West, Professor of Medi-

cine at the University of Oklahoma, said: "The coronary arteries of Asian diabetics of long duration who have never seen a doctor are in much better shape than the coronary arteries of a typical diabetic of the 'advanced' societies who has had the advantage of the traditional diabetic diet prescribed by the Western physician."

Other epidemiologic studies have implicated environmental more than genetic factors as a cause of associated coronary artery disease in diabetes, Dr. West said. The clinical meaning of these findings, he commented, is that "we should consider whether the traditional diabetic diet prescribed by Western physicians is really the most appropriate."

Eastern clinicians have long used high-carbohydrate diets in controlling diabetes, and it is now obvious that the use of such diets has been associated with very low rates of atherosclerosis, Dr. West observed.

The Indian study, by Dr. B. B. Tripathy,

was performed on a sample of 5,055 urban and 1,848 rural subjects in the Cuttack area. While the prevalence of overt diabetes among urban persons was 1.2 per cent, which compares well with most figures from Western countries, in the rural population the prevalence was 0.38 per cent, "giving an idea how urbanization affects people of the same genetic stock."

Findings Similar in Japan

Many of Dr. Tripathy's findings, particularly the reversal of the Western sex ratio and low rate of cardiovascular complications, were said by Dr. Y. Goto, of Hiroaki University, to apply in Japan.

Dr. West pointed out that in a multinational study of the relationship of diabetes to certain epidemiologic variables, the most impressive and consistent association was between prevalence of diabetes and adiposity. He agreed, however, that in other population studies it is clear that

adiposity is by no means the sole determinant of risk.

Dr. Peter H. Bennett, of the National Institutes of Health Epidemiology and Field Studies Branch in Phoenix, Ariz., said that the Pima Indians in the southwest United States have the highest prevalence of diabetes in the world and that their diabetes appears to be biochemically and clinically the same in all its specific manifestations as diabetes mellitus in other races in the West. As such, he noted, they represent a model population for the study of the natural history and determinants of diabetes mellitus and its complications.

Abortion in India

Medical Tribune World Service

BOMBAY, INDIA—Of the 75 incomplete abortion cases admitted to the Medical College Hospital at Baroda during a two-year period, 77.4 per cent were in married women. The most common method of inducing abortion was introduction of a vegetable stick into the uterus, used in 41.3 per cent.

Merrell

Tenuate® (diethylpropion hydrochloride N.F.)

DRUG SUMMARY

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct to a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

While diethylpropion, the active ingredient in Tenuate Dospan, has been classified as "effective" by the FDA for the above indication, based on a review by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the drug as a controlled substance because of its "possibly" addictive potential.

CONTRAINDICATIONS: Advanced arteriosclerosis, glaucoma, hypertension, hyperthyroidism, or idiosyncrasy to sympathomimetic amines, and agitated states. Tenuate is also contraindicated in patients with a history of drug abuse and during or within 14 days following administration of MAO inhibitors. It is also contraindicated in patients with a history of alcoholism.

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly.

Drug Dependence: Tenuate has some chemical and pharmacologic similarities to the amphetamines and other stimulant drugs that have been extensively abused. There are occasional reports of subjects dependent on amphetamines later chronically abusing diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychosis, including delirium and acute dystonia which, in the case of amphetamines, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abuse of amphetamines and related drugs may also result in extreme fatigue and mental depression; changes are also noted on the sleep EEG.

Use in Pregnancy: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks.

Use in Children: Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with asymptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetic patients may be altered in association with the use of Tenuate and the appropriate dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount of Tenuate should be prescribed or dispensed at one time in order to minimize the possibility of overdose. Patients exposed to Tenuate may increase convulsions in some epileptics and, therefore, epileptics receiving Tenuate should be carefully monitored. Duration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: Cardiovascular: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmias. A limited report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. Central Nervous System: Dizziness, tremor, headache, euphoria, restlessness, drowsiness, irritability, insomnia, anxiety, nervousness, depression, euphoria, tremor, and a few episodes of psychotic episodes at recommended doses have been reported. Gastrointestinal: Dryness of the mouth, anorexia, nausea, vomiting, abdominal discomfort, flatulence, constipation, other gastrointestinal disturbances. Endocrine: Changes in libido, menstrual cycle. Hematologic: Changes in hemoglobin, hematocrit, erythrocyte count, and bone marrow depression. Laboratory: A variety of miscellaneous blood test abnormalities have been reported by physicians. These include, among others, changes in serum electrolytes, liver function tests, and blood urea nitrogen.

Overdosage: Overdosage may result in drowsiness, headache, and other symptoms. In severe cases, convulsions, coma, and death have been reported. Treatment should be symptomatic and supportive.

How to Use: One 75 mg. controlled-release tablet, swallowed whole in morning and evening with meals. Do not chew or crush. Do not take more than one tablet daily, one hour before or after meals.

Merrell-National Laboratories
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Kenilworth, Ohio 44139

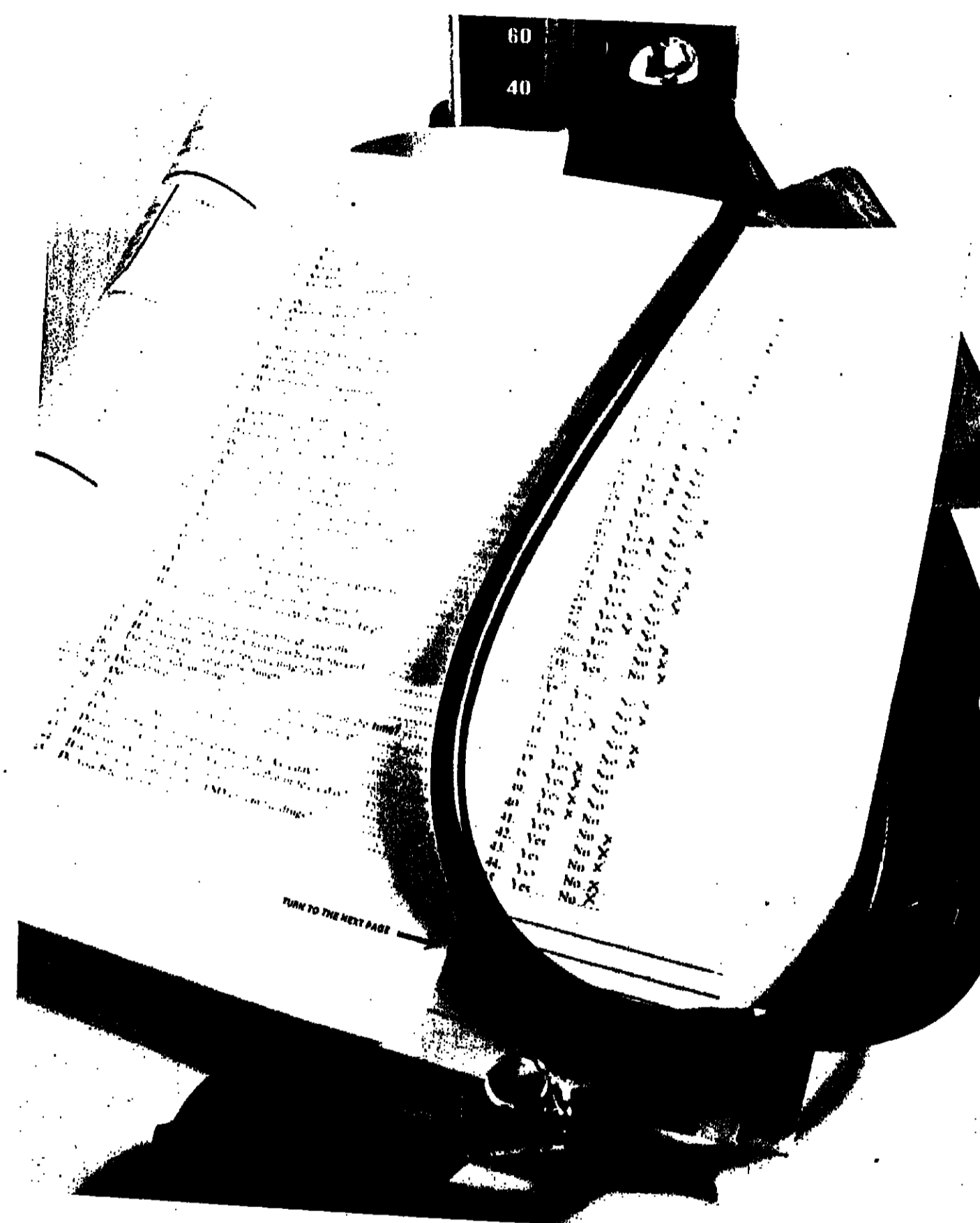
In the medical management of obesity... early weight loss can be critical to patient motivation.



Tenuate®
(diethylpropion
hydrochloride N.F.)

Merrell

"Anxiety hypertension" superimposed on essential hypertension



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

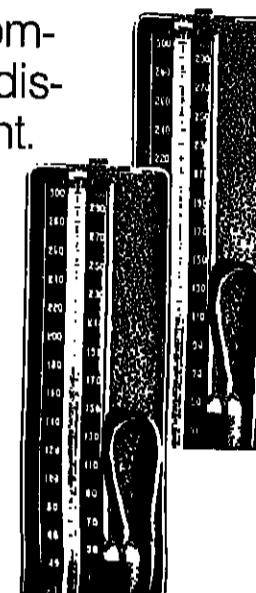
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete

mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic

The Somatic Protest

Excessive anxiety or apprehension can initiate a sequence of complex neurohormonal events which, in susceptible patients, may lead to *anxiety hypertension*. Superimposed on hereditary essential hypertension, this can complicate the course of the disease and its management. Excessive anxiety may be an emotional response to endogenous or environmental stress, and is often reported to result not only in higher blood pressure but also in tachycardia or cardiac arrhythmias. Transient B.P. elevation may occur when the measurement is made in the physician's office. In some hypertensive patients, awareness of the disorder alone can generate anxiety severe enough to increase the blood pressure.



The adjunctive use of Librium (chlordiazepoxide HCl) can help reduce excessive anxiety complicating essential hypertension. Physicians have found Librium to be dependably effective against clinically significant anxiety.

Librium is used concomitantly with certain primary medications, such as cardiac glycosides, diuretics, antihypertensives and vasodilators. Because of its wide margin of safety, the necessity of discontinuing therapy with Librium because of undesirable effects has been rare. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See summary of product information.) Librium is available in 5-mg, 10-mg and 25-mg capsules, permitting individualized treatment of varying levels of anxiety.

For moderate to severe anxiety aggravating essential hypertension

adjunctive

Librium® 10 mg
(chlordiazepoxide HCl)
1 or 2 capsules t.i.d./q.i.d.

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG

patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

MD Wives Move to Assert Separate Identity

Continued from page 1

evidence of instability around them all the time.

"There's a gal who lives down the block," one wife relates. "She's got a lot of potential, a lot of talent, but she doesn't place any value on her own identity. As a result, she's smoking more, losing a lot of weight, and becoming depressed. She hasn't taken up drinking yet, but I would expect her to."

For some of these women, awareness comes too late. At the May meeting of the American College of Obstetricians and Gynecologists during a workshop for wives on female sexuality and interpersonal relationships, a number of wives in their 40s and 50s—the picture of total composure on the outside—broke down in tears when they confessed in the group sessions how totally empty their lives were. One said she was particularly frustrated because she could not discuss her feelings with her husband.

The societal conditioning to stay in very structured roles overcomes many of these women.

"I had the idea," says Shirlene Cutler of Murray, Utah, the wife of a family physician, "that if I married a professional man and got my china and silver and house in the suburbs and had three children—and got both sexes—that I would be completely happy, because that's what I had been told."

Had Time on Her Hands

When she achieved all that, after being married for 10 years, she found that she had so much time on her hands that she got bored.

"In rural communities where the doctor has to deliver babies and do so many things," she says, "if you're going to stand waiting for your husband to come home, you're going to be waiting most of your life away, and that's quite a waste of human resources."

At the same time, she became concerned about legal protection for doctors from investment schemes aimed at them, and she decided to enter law school. Explaining her decision, she says:

"I've seen so many cases of women pushing their husbands and pushing their children when they don't have the guts to do it themselves. I think you should set an example. You can't try to perfect other people all the time when you see how tough it is out in the world itself."

The heat of the fire has not forced Mrs. Cutler back to the kitchen, but it has made things uncomfortably warm for her husband at times.

"Many of my husband's friends," she explains, "thought he was absolutely insane. They kept asking, 'Why are you letting her?' It's been difficult for him. One time he got angry in the O.R. because he felt the staff wasn't giving him the right assistance and he was acting grouchy, and everyone ran around the hospital saying, 'Well, you know, it's because of his wife and the Women's Liberation.'"

In spite of these difficult adjustments, Mrs. Cutler's move has created a profound, positive change in her marriage.

"People thought we would probably be divorced if I went to law school," she says, "but I think it's made our marriage stronger. I have things to discuss with him, and he has things to discuss with me. He has become very interested in law, too, and has thought about going to law school himself. It's opened up a whole new life for us."

There Are Holdouts

But for every Shirlene Cutler, there's at least one holdout for the old school, like a neurologist's wife at the A.M.A. convention who said matter-of-factly, "If your husband didn't have such a good reputation, you wouldn't be anything." That's the kind of thinking that prompted Barbara Jarvis, wife of a Phoenix, Ariz., pathologist, believing, as she does, in working for change through the system, to become a politically active consciousness-raiser as president of the Arizona Medical Association Auxiliary.

Her efforts to heighten awareness are no easy task.

"If you talk to the average doctor's wife," she says, "and ask her if she's aware that her husband doesn't need to support her, it's just that he's a nice guy, she doesn't understand that. And she doesn't feel that what she does at home is as important as what he does."

"I've been doing some reporting on health care of doctors' wives, and my question to them has been: Do you think it's an invasion of privacy when your personal physician calls your husband and discusses you—which he would never do if you were anybody else? They feel that's no encroachment at all. They don't have any feeling that they're not just an extension of the husband."

Up in Portland, Ore., doctor's wife Kathryn Biska shares Mrs. Jarvis' concern over the fate of her less liberated fellows.

"I think many of them have sort of shrouded themselves in the medical image of their husbands," she says, "and, as a result, there is a deterioration, because they are no longer stimulating companions and they are divorced from the work of their husbands."

Mrs. Biska edits the local Women's

Auxiliary newsletter, which she took over three years ago when it was a mimeographed social rundown on who wore what. Now it has taken a gutsier turn. Her pet project: enlisting aid to resist socialized medicine.

Wives "Have Mandate"

"I think doctors' wives have a thing they need to be doing that's very aggressive if medicine is not to be leaping into socialism," she says. "Doctors are too busy to be doing this. I think doctors' wives have a mandate to take on a personal identity in terms of promoting health care, especially in the area of preventive medicine."

Both Mrs. Biska and Mrs. Jarvis are critical of the structure of the Women's Auxiliary from a feminist point of view.

"I'm really against its being an auxiliary," says Barbara Jarvis, "but bucking that is like knocking your head against a stone wall."

Mrs. Biska reports, "In Multnomah County, the women have to ask before they can move. I think that's sort of idiotic. The implication is that the doctors will decide what activities are suitable for their wives."

On the personal level, it is certainly true that doctor-husbands do to a large extent determine what activities are suitable for their wives. All of the women who have managed to find an identity of their own have very encouraging husbands—liberated in their own right. One gynecologist sees women in his office all the time who remind him of what his wife could have become. In their late 40s, these women are filled with despair.

"They've done all the charities," he says, "and they feel they have nothing. I encourage them to go back to school, to do something outside the home."

His wife, who feels his attitude has been the key to her finding herself, explains: "My husband is extremely open to fulfillment of individuals. If you feel that way, it opens up all sorts of doors. You're not imprisoned by what a woman can or can't do. They say that behind every woman who's been more than a housewife is a really supportive husband."

Arthritis Added to Study

Medical Tribune World Service

Moscow—The United States and the Soviet Union have agreed to add arthritis to a Joint Study of Heart Disease, Cancer, and Environmental Health.

Increase Forecast In Respiratory Ills In Next 30-40 Years

Medical Tribune World Service

PERTH, AUSTRALIA—A big increase in respiratory viruses throughout the world within the next 30 or 40 years was forecast here by Prof. Frank Fenner, director of the Center for Resource and Environmental Studies at the Australian National University, Canberra.

He made the prediction in the David Memorial Lecture to the Australian and New Zealand Association for the Advancement of Science.

An explosive spread of respiratory viruses in people and perhaps animals may be expected as populations grow and domestic animals become more numerous, more mobile, and more crowded, he said.

Most of the new viruses will probably produce trivial disturbances, but there is a possibility of a dramatically severe disease, Professor Fenner warned.

"It appears likely that every living species of organism carries at least one virus, and some can be infected with many more," he said.

Subject of Diet Study



Dr. Gary Moore (left), of the Southwest Foundation for Research and Education in San Antonio, and Dr. Henry McGill (right), of the University of Texas, examine an infant baboon of the type whose diet will be studied in a major research project in atherosclerosis. Diets of varying cholesterol content will be studied along with behavior patterns in the offspring of 100 baboons at S.F.R.E.'s baboon colony. The National Heart and Lung Institute financed the program.

Australian Plan Would Give MDs Federal Salaries

Medical Tribune World Service

SYDNEY, AUSTRALIA—A group of general practitioners here has prepared a plan for Australia's 11,000 doctors in private practice to become wage earners on the Government payroll.

Author of the plan, aimed at ending the current confrontation between the Australian Medical Association and the Government, is Dr. T. J. O'Neill, a former branch counselor of the medical association and a leading member of the Royal Australian College of Practitioners.

The formal proposal for a fully-salaried medical service has been submitted to the Ministries for Social Security and Health.

"A lot of my patients think I am a dyed-in-the-wool conservative because I've been a branch counselor of the Australian Medical Association," Dr. O'Neill said. "I tell them I would only be too pleased for the Government to give me a car, pay me a good salary, and let me get on with practicing good medicine."

The general practitioners' scheme is even more radical than the Government's plan, which is to allow continued private practice by doctors, with patients' bills handled by a single Government fund. The Government would pay the doctors directly through a bulk billing arrangement.

Dr. O'Neill would like to see all physicians on salary to the Government and graded according to experience and skills. The stage has been reached, he said, where the welfare of the patient will suffer if the conflict between the Social Security Minister and the medical profession on the fees issue continues.

Role of Altered Bacteria In Urinary Infections Supported by New Study

Medical Tribune World Service

JERUSALEM—Support of the theory of a link between altered bacteria and chronic urinary tract infections was given here by a Tulane Medical Center investigator.

In a five-year study of 2,000 patients with chronic urinary tract infections, Gerald J. Domingue, Ph.D., found that approximately 20 per cent had cell wall-defective bacteria, known as L-forms, in their urine. He suggested that these may be responsible for relapsing urinary tract infections.

Dr. Domingue, who is Associate Professor of Microbiology and Immunology and of Surgery, presented his findings at the first International Congress of Bacteriology. Other members of the Tulane research team were Drs. Jorgen U. Schlegel, Keith Lloyd, Bruce Turner, Andres Daniel, and Alfred J. Colfey, Jr., and Mary Green.

In patients with urinary tract infections treated with antibiotics, Dr. Domingue said, some organisms are not destroyed, and survive in the kidney or urinary tract as altered bacteria.

Unless specific measures are taken to eliminate them, the entire infectious process could become uncontrollable, possibly fatal, he said.

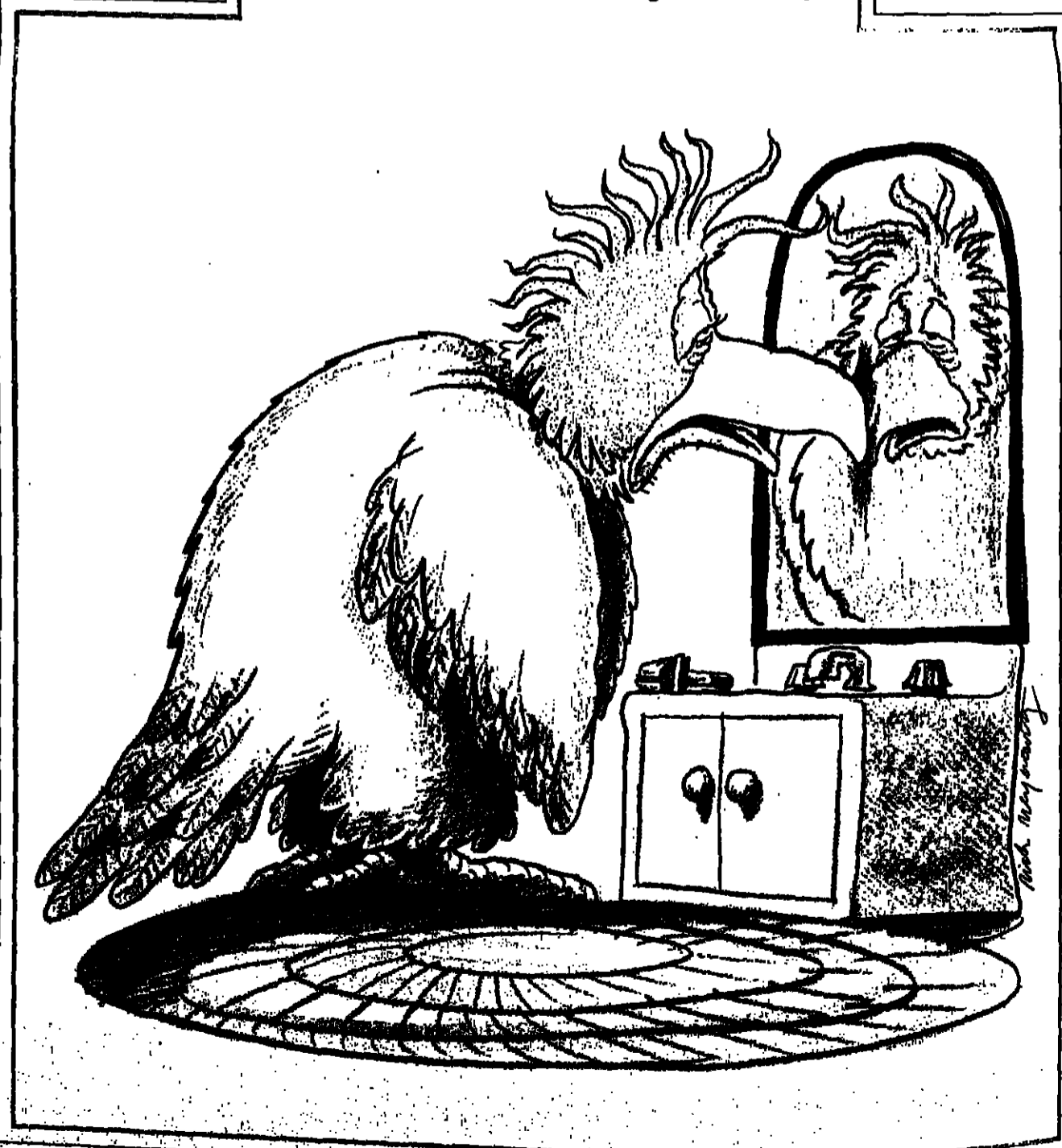
Using germfree rats bred in the Tulane medical school vivarium, Dr. Domingue injected one group of animals with L-forms developed in his laboratory and others with the parent bacteria known to cause disease.

One group injected with the L-forms was treated with penicillin, and experiments at varying time intervals showed intact L-forms in the liver, spleen, brain, kidneys, blood, urine, and stool of these animals.

The investigation demonstrated, Dr. Domingue said, that L-forms can survive for long periods without causing clinical disease in animals, and also that they can ultimately cause disease when they revert to ordinary bacteria.

THE HEAVY-LIDDED HACKER

from the Ornacologist's Guide to Cough/Cold Patients



SYMPTOMS

- sleep-robbing cough
- stuffy nose

ORNACOL

Ornacol is a powerful, effective, and safe cough suppressant. It is the only cough suppressant that is also a decongestant. It is the only cough suppressant that is also a bronchodilator. It is the only cough suppressant that is also a mucolytic. It is the only cough suppressant that is also a sedative. It is the only cough suppressant that is also a hypnotic. It is the only cough suppressant that is also a tranquilizer. It is the only cough suppressant that is also a muscle relaxant. It is the only cough suppressant that is also a pain reliever. It is the only cough suppressant that is also a fever reducer. It is the only cough suppressant that is also a blood thinner. It is the only cough suppressant that is also a blood pressure lowering agent. It is the only cough suppressant that is also a heart rate lowering agent. It is the only cough suppressant that is also a heart rate increasing agent. It is the only cough suppressant that is also a heart rate regulating agent. 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R.S.V.P.

She just doesn't respond to things. No interest. No energy. Discouraged.

It may be mild depression. She needs help...and she needs it now. Counsel and reassurance may suffice. But if you decide supportive

medication is indicated, Ritalin can offer prompt benefit.

Ritalin usually begins to act with the very first dose...boosts spirits and brightens mood...helps the patient get moving again. And

Ritalin is generally well tolerated, even by older and convalescent patients. However, Ritalin should not be used for severe depression.

When Ritalin works, one prescription may be enough...to help provide an answer to mild depression.

Ritalin® (methylphenidate)

helps the patient respond
in mild depression*

*This drug has been evaluated as possibly effective for this indication. See brief prescribing information.

Ritalin® hydrochloride
(methylphenidate hydrochloride)

TABLETS

INDICATION

Based on a review of this drug by the National Academy of Science-National Research Council and/or other information, FDA has classified the indication as follows: "Possibly" effective: Mild depression. Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS

Marked anxiety, tension, and agitation, since Ritalin may aggravate these symptoms. Also contraindicated in patients known to be hypersensitive to the drug and in patients with glaucoma.

WARNINGS

Ritalin should not be used in children under six years, since safety and efficacy in this age group have not been established. Sufficient data on safety and efficacy of long-term use of Ritalin in children with minimal brain dysfunction are not yet available. Although a causal relationship has not been established, suppression of growth (ie, weight gain and/or height) has been reported with long-term use of stimulants in children. Therefore, children requiring long-term therapy should be carefully monitored.

Ritalin should not be used for severe depression of either exogenous or endogenous origin or for the prevention of normal fatigue states. Ritalin may lower the convulsive threshold in patients with or without prior seizures, with or without EEG abnormalities, even in absence of seizures. Safe concomitant use of anticonvulsants and Ritalin has not been established. If seizures occur, Ritalin should be discontinued. Use cautiously in patients with hypertension. Blood pressure should be monitored at appropriate intervals in all patients taking Ritalin, especially those with hypertension.

Drug Interactions

Ritalin may decrease the hypotensive effect of guanethidine. Use cautiously with pressor agents and MAO inhibitors. Ritalin may inhibit the metabolism of coumarin anticoagulants, anticonvulsants (phenobarbital, diphenhydantoin, primidone), phenylbutazone, and tricyclic antidepressants (imipramine, desipramine). Downward dosage adjustments of these drugs may be required when given concomitantly with Ritalin.

Usage in Pregnancy

Adequate animal reproduction studies to establish safe use of Ritalin during pregnancy have not been conducted. Therefore, until more information is available, Ritalin should not be prescribed for women of childbearing age unless in the opinion of the physician, the potential benefits outweigh the possible risks.

Drug Dependence

Ritalin should be given cautiously to emotionally unstable patients, such as those with a history of drug dependence or alcoholism, because such patients may increase dosage on their own initiative. Chronically abusive use can lead to marked tolerance and psychic dependence with varying degrees of abnormal behavior. Frank psychotic episodes can occur, especially with parenteral abuse. Careful supervision is required during drug withdrawal, since severe depression as well as the effects of chronic overactivity can be unmasked. Long-term follow-up may be required because of the patient's basic personality disturbances.

PRECAUTIONS

Patients with an element of agitation may react adversely; discontinue therapy if necessary. Periodic CBC, differential, and platelet counts are advised during prolonged therapy.

ADVERSE REACTIONS

Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, erythema multiforme with histopathological findings of necrotizing vasculitis, and thrombocytopenic purpura); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood pressure and pulse changes, both up and down; tachycardia; angina; cardiac arrhythmia; abdominal pain; weight loss during prolonged therapy. Toxic psychosis has been reported. Although a definite causal relationship has not been established, the following have been reported in patients taking this drug: leukopenia and/or anemia; a few instances of scalp hair loss. In children, loss of appetite, abdominal pain, weight loss during prolonged therapy, insomnia, and tachycardia may occur more frequently; however, any of the other adverse reactions listed above may also occur.

DOSEAGE AND ADMINISTRATION

Adults: Administer orally in divided doses 2 or 3 times daily, preferably 30 to 45 minutes before meals. Dosage will depend upon indication and individual response. Average dosage is 20 to 30 mg daily. Some patients may require 40 to 60 mg daily. In others, 10 to 15 mg daily will be adequate. A few patients who are unable to sleep if medication is taken late in the day should take the last dose before 6 p.m.

HOW SUPPLIED

Tablets, 20 mg (peach, scored); bottles of 100 and 1000.
Tablets, 10 mg (pale green, scored); bottles of 100, 500, 1000 and Accu-pak blister units of 100.
Tablets, 5 mg (pale yellow); bottles of 100, 500 and 1000.
Consult complete product literature before prescribing.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

C I B A

Wednesday, October 3, 1973

MEDICAL TRIBUNE

23

Medicine's Role In the Movement

Surrealism Sought 'Diamonds in the Flesh'

If the world of medicine often seems surrealistic—from the giant walk-in kidney of a medical convention exhibit to a motorized prosthesis—Surrealism, in turn, has drawn vastly on medicine for inspiration.

Anatomic forms are common in the paintings of the most celebrated Surrealist of all, Salvador Dali. His major works, as exemplified in "The Forgers" and "Men Who Eat One Another" from the well-known *Purgatory* series—now available to entrants in the MEDICAL TRIBUNE Sweepstakes (see page 3)—seem to have been executed by a medical illustrator run amok, strewn his canvases with bones, shaws, and pieces of flesh.

To link contortions of the human form to science and medicine seems sheer *Hip-pocritry*, until one understands the *raison d'être*, which is to reveal the mysterious relationships behind the marvels of life by laying bare the flesh with a brush as scalpel. This desire to uncover "diamonds in the flesh" was only part of the over-all Surrealist design, however. As understood—and lived—by early disciples, the movement was intended to initiate a new humanism in which talent per se did not exist, in which every man was an artist, serving as medium for a broad new consciousness that would change the world.

Although Dali's name is synonymous with the Surrealist concept today, he was not on hand for the movement's painful birth. Squeezed into time (1924-39) and space (Paris), the infant movement was shaken by quarrels and weakened by posturing from its inception, when it appeared as the culmination of avant-garde artistic trends that had permeated the air since 1885. André Breton, Louis Aragon, Paul Eluard, and Benjamin Peret—young petit-bourgeois intellectuals who condemned as futile every activity expected of them by their background—founded Surrealism "on the belief in the higher reality of certain forms of association neglected until now, on the all-power of dream, on the undirected free play of thought."

In the *Manifesto of Surrealism* (1924), Breton defined Surrealism "as pure psychic automatism by means of which we propose to express . . . the true function of thought." Basically, the true function of thought was conceived of as a kind of "dictation," free of "any control exercised by reason, outside of all aesthetic or moral considerations."

Three methods were originally em-

ployed by Surrealists to skirt normal controls: automatic writing, spiritism, and love. All these activities depend on chance rather than determinism; thus, they were thought to be expressive of both randomness and a hidden order of reality. This brings into play the collage aesthetic, which underlies much Surrealist art and is based on a chance "reconciliation of two distant realities" on a new and unexpected plane. The collage aesthetic derives from punning, which was brought to a magnificent and outrageous height by James Joyce, who, although no Surrealist, undoubtedly knew of the movement's activities.

Potential Way of Life

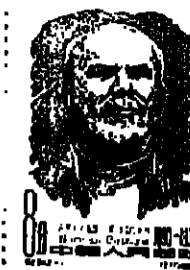
Mad love (*l'amour fou*) was considered the most advanced form of automatism, since it had the potential of becoming a way of life. It was perhaps in *l'amour fou* that the Surrealists had the best chance to reconcile their interest in the irrational with their other major preoccupation—social revolution—but such a reconciliation was never to occur. By 1929, when Dali put in his first appearance with the Surrealists at the Café Cyrano in Paris, the

heroic years of the Surrealist movement were already past and only crisis lay ahead. Breton's *Second Manifesto of Surrealism* (1930), which critically examined both the Communist Party and Surrealist literary artistic activity, contributed strongly to contention over the correct relationship vis-à-vis Surrealism and politics.

Amid the turmoil, many Surrealists saw in Dali's hallucinatory paintings a direct dictation from the unconscious, representing a refreshing return to Surrealism's youth; they hoped he would save the movement from the academism and bickering that threatened to destroy it. Indeed, "for three or four years," according to Breton, "Dali incarnated the Surrealist spirit."

But, by 1934, he was in deep trouble with the movement over a burgeoning obsession with Hitler and Franco—an obsession that was dream-driven and never translated into express admiration. Alienated finally from the entire Surrealist camp, Dali left for America in 1939 to pursue an independent, sensational career. Breton soon followed; at the decade's close, purges and defections had all but desiccated Surrealism as a movement.

Norman Henry Bethune



Born in Gravenhurst, Ont., Norman Henry Bethune (1890-1939) received his M.D. from the University of Toronto in 1916. An uncompromising Communist, he was ostracized by members of the Canadian Medical Association. He traveled to China in 1938 to help the Red Army and died a year later from an infection.

The People's Republic of China issued the stamp in 1960 to honor Bethune, whom they regard as a saint of their liberation struggle and a model of revolutionary selflessness.

Text: Dr. Joseph Kler

Stamp: Minkus Publications, Inc., New York



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- A unique, specific cerumenolytic, CERUMENEX Drops enable you to avoid painful instrumentation.
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Indications: Removal of excess or impacted cerumen; removal of cerumen prior to ear examination, otologic therapy, or audiometry. Contraindications: Previous untoward reaction to the drops; positive patch test. Precautions: Patch test in patients with suspected or known allergy. Use with caution in otitis externa, otitis media, presence of perforated drum, known dermatologic sensitivity or other allergic manifestations. Avoid undue exposure of large skin areas to the drug. Adverse Reactions: Reported incidence in clinical studies* is about 1%, ranging from mild erythema to severe eczematoid reaction of external ear and periauricular tissue; all reported uneventful resolution and no sequelae. *Bibliography and detailed literature available upon request.

Cerumenex Drops

(triethanolamine polypeptide oleate-condensate
10.0% in propylene glycol with chlorbutanol 0.5%)

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The root of antihypertensive therapy



Serpasil...where antihypertensive therapy often begins

Most investigators believe that elevated blood pressure should be controlled to help prevent future complications. But selection of treatment must be based upon the overall condition of the patient—young and old alike. Once you decide on antihypertensive treatment, Serpasil may be a logical choice.

Serpasil...a quality reserpine, assured by quality control

Serpasil, the original reserpine, is established as a quality reserpine. Exact quality control procedures, including 99 tests performed during the manufacturing process, help guarantee its purity, uniformity, and potency.

Serpasil lowers blood pressure and slows rapid heart rate

Serpasil acts both on the autonomic and central nervous systems, lowering arterial blood pressure and slowing rapid heart rate.

Serpasil reduces the "tension" in hypertension

Serpasil eases the "tension" that plays an important part in many cases of hypertension.

Warning: Mental depression, occasionally severe, can occur with use of Serpasil. Discontinue drug at the first sign of depression.

Serpasil...the antihypertensive to build on

If you decide to use Serpasil in combination with other antihypertensive agents, lower dosage of these drugs is permitted, minimizing the incidence and severity of their side effects... an important consideration, particularly in treating the older patient.

Serpasil® (reserpine)

Tablets / Elixir
INDICATIONS
Mild essential hypertension; adjunctive therapy with other antihypertensive agents in the more severe forms of hypertension.
CONTRAINDICATIONS
Known hypersensitivity; mental depression (especially with suicidal tendencies); active peptic ulcer; ulcerative colitis; electroconvulsive therapy.

WARNINGS
Use with extreme caution in patients with a history of mental depression. Discontinue at first sign of despondency, early morning insomnia, loss of appetite, impotence, or self-deprecation. Drug-induced depression may persist for several months after drug withdrawal and may be severe enough to result in suicide.
MAO inhibitors should be avoided or used with extreme caution.

Usage in Pregnancy
The safety of reserpine for use during pregnancy or lactation has not been established; therefore, the drug should be used in pregnant patients or in women of childbearing potential only when, in the judgment of the physician, it is essential to the welfare of the patient. Increased respiratory tract secretions, nasal congestion, cyanosis, and anorexia may occur in neonates and breast-fed infants of reserpine-treated mothers since reserpine crosses the placental barrier and appears in maternal breast milk.

PRECAUTIONS
Use cautiously in patients with history of peptic ulcer, ulcerative colitis, or gallstones (biliary colic may be precipitated). Exercise caution when treating hypertensives with renal insufficiency. Use cautiously with digitalis and quinidine. Intraoperative hypotension has occurred in hypertensive patients receiving rauwolfia preparations, but withdrawal of reserpine does not assure that circulatory instability will not occur in such patients.

ADVERSE REACTIONS
Gastrointestinal—hyposecretion; nausea; vomiting; anorexia; diarrhea.
Cardiovascular—angina-like symptoms; arrhythmias (particularly when used concurrently with digitalis or quinidine); bradycardia.
Central Nervous System—drowsiness; depression; nervousness; paradoxical anxiety; nightmares; Parkinsonian syndrome and other extrapyramidal tract symptoms; CNS sensitization (manifested by dull somnolence, dizziness, headache, vertigo, and optic atrophy).

Miscellaneous—frequently noted congestion; pruritus; rash; dryness of mouth; dizziness; headache; dyspepsia; syncope; epistaxis; purpura and other hematological reactions; myalgia or decreased libido; dysuria; muscular aches; conjunctival injection; weight gain; breast engorgement; pseudotumor; gynecomasia; rarely water retention with edema in hypertensive patients.

DOSEAGE
For Hypertension: In the average patient not receiving other antihypertensive agents, the usual initial dose is 0.5 mg daily for 1 or 2 weeks. For maintenance, reduce to 0.1 mg to 0.25 mg daily. Higher doses should be used cautiously, because serious mental depression and other side effects may be increased considerably. Concomitant use of Serpasil with ganglionic blocking agents, guanethidine, veratrum, hydralazine, methyldopa, chlorbutolone, or thiazides necessitates careful titration of dosage with each agent.

HOW SUPPLIED
Tablets, 1 mg (white, scored); bottles of 100, 500, 1000 and 5000.
Tablets, 0.25 mg (white, scored); bottles of 100, 500, 1000 and 5000.
Tablets, 0.1 mg (white); bottles of 100, 500 and 1000.
Elixir (green, lemon-lime flavored), 0.2 mg per 4-ml teaspoon; bottles of 1 pint. Consult complete literature before prescribing.

CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07991

Serpasil®
(reserpine)
early effective control of hypertension can save lives
C I B A

Clinical Trials



by Oldden

Distress Phone Calls—for MDs or Laymen?

Medical Tribune World Service
GENEVA, SWITZERLAND—The suggestion that a physician, preferably a psychiatrist, should have the chief role in handling telephone distress calls stirred debate here at an international conference of the Federation of Services of Emergency Telephone Help.

The view was advanced by Dr. Adam Bukoczyk, of the Warsaw University Psychiatric Clinic, who pointed out that the most frequent problems prompting distress calls relate to conflict situations and neurotic reactions.

He noted that the emergency services in Eastern Europe are usually staffed by members of the medical profession, whereas lay volunteers answer calls in Western Europe.

On the other side of the argument, the founder of the first telephonic help service, Chad Varah, rector of St. Stephen's Church, London, said that people dialing

a number for emergency help are not primarily interested in medical assistance but rather want a human contact.

The keynote speaker at the conference, a psychiatrist himself, Dr. Pierre Bailly-Salin, of the Paris Health and Social Services, said he fears possible undue "psychiatrization" of emergency telephonic help.

The psychiatrist's role in emergency telephonic help should be that of an adviser, he said; a volunteer lay person should be the one to reply to emergency calls.

Psychiatrist Could Be Trainer

He advocated that the psychiatrist par-

ticipate in the selection and education of the lay listeners as a "trainer" in regular group therapy session.

In an interview with MEDICAL TRIBUNE, Dr. Bailly-Salin said that "the main goal of emergency telephonic help should not be to attract new patients to psychiatric clinics but rather to offer a humane service to listeners and callers whose lives and work have lost their human quality in modern society."

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prescribing convenience: up to 5 refills in 6 months, at your discretion (unless restricted by state law); by telephone order in many states.

Empirin Compound with Codeine No. 3, codeine phosphate* 32.4 mg. (gr. ½), No. 4, codeine phosphate* 64.8 mg. (gr. 1). *Warning—may be habit-forming. Each tablet also contains: aspirin gr. 32½, phenacetin gr. 2½, caffeine gr. ½.

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WHEREVER IT HURTS

HERE Osteoarthritis



EMPIRIN COMPOUND c CODEINE

#3, codeine phosphate* (32.4 mg.) gr. ½
#4, codeine phosphate* (64.8 mg.) gr. 1

If there's good reason
to prescribe
for psychic tension...



Prompt action
is a good reason
to consider Valium®
(diazepam)

When, for example, despite counseling, tension and anxiety continue to produce distressing somatic symptoms

When your patient's somatic complaints are associated with tension and anxiety and you have tried counseling and other supportive measures alone, you may decide to prescribe psychotherapeutic medication. If you do, the question remains: Which one?

Valium (diazepam) is one to consider closely. One that works promptly as an adjunct to continued supportive measures. One that generally produces significant improvement within

the first few days of therapy, although some patients may require more time for a clear-cut response.

Prompt action. One good reason to consider Valium (diazepam).

And should you choose to prescribe Valium, you should also keep this information in mind: Valium is usually well tolerated; the most common side effects reported have been drowsiness, fatigue and ataxia.

As with all CNS-acting agents, patients should be cautioned against operating dangerous machinery or driving. Normally, therapy with Valium (diazepam) should be continued until the patient's psychic tension symptoms have been reduced to tolerable levels.

Please turn page
for a summary of product
information.

Valium® ROCHE
(diazepam)
2-mg, 5-mg, 10-mg tablets

Other good reasons to consider Valium® (diazepam)

Effectiveness

The efficacy of Valium (diazepam) has been proven in clinical studies and in extensive clinical use. It can relieve psychic tension and its somatic symptoms in patients who overreact to stress and in psychoneurotic patients.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states, somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or

Dependable response

The psychotherapeutic effect of Valium (diazepam), characterized by symptomatic relief of tension and anxiety, is generally reliable and predictable.

severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in

Titratable dosage

With Valium (diazepam), adjustments in dosage can alter the clinical response. This titratibility enables you to tailor your therapy for maximum efficiency. There are three convenient tablet strengths to choose from: 2 mg, 5 mg and 10 mg.

salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose® packages of 1000.



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Tribune Economic Analysis

Customer Is Always Right—Even in Stocks

By ELIOT JANEWAY
Publisher of Janeway Service

"THE CUSTOMER IS ALWAYS RIGHT," said R. H. Macy, one of the greatest merchants in the history of goods pushing. This memorable dictum holds the key to the riddle of today's stock market.

Merchandising stocks, however, is a different kind of business from pushing inventory off the retail floor past the cash register. The customers buy the merchandise they can see and feel in the store. But the securities they wind up with are sold to them.

In line with this difference, department stores are organized to facilitate customer selection, while brokerage firms jumble the offerings. In department stores, the furniture is in one department, the clothing in another—so that dining room chairs never get confused with milk stools, much less with boys' belts.

Brokerage firms have been casual in mixing the merchandise. They have pushed milk and junk interchangeably. Until the going got rough on Wall Street, the easy sell was enough. Anything goes was the rule. As long as more stocks were going up than down, the customers were complacent about being stuck with occasional losers. Winning with dogs conditioned them to look for baby IBMs in every issue. For a while, the impression spread that chasing stocks was a passport to instant wealth.

For a while, too, the shoe salesman and the doctors' wives in the market were bragging about doing as well as the hottest "go-go" fund managers. All too few brokerage firm managements held out against the speculative craze. But the amateurs and professionals alike who were running wild playing blindman's bluff on Wall Street soon discovered that it is a two-way street.

Before today's two-tier market of growth and cyclical stocks became the vogue, a two-class market of insiders and outsiders was taken for granted. Exactly as in the department store business, the insiders were assumed to have standing invitations to the previews. The outsiders woke to find themselves owning the merchandise advertised at the clearances. Rubbing salt in the wound, the insiders won an edge in commission costs.

Continued Chasing Stocks

The stock market, though hurt, was able to hold its own while the outsiders felt bad but the insiders still looked good. While they still did, the money they were making encouraged them to continue chasing stocks. The longer they did, the more they were encouraged by the hope that their success stories would bring the lost sheep from Main Street back into the chase.

Stocks are not likely to regain their lost competitiveness until the Government regains its lost respectability. Interest rates will drop only when it does, not until.

But in terms of market factors, the volume of daily trading is the key to the price trend. Higher prices will not come back until higher volume brings them back. But people make markets. Put in terms of people, the key to higher trading volume is more people investing. The retail money-using public will not go shopping for stocks again until it is ready to buy declarations of the Government at face value. Until it is, market rallies will merely measure false starts by professional handicappers kidding themselves.

The soft spots in the American economy are easier to detect at the outset of the new business year, beginning this Labor Day, than in many a year. Three conspicuous ones are here—and here to stay for a while. The way to recite the "ABC" of the 1973-74 recession story is

money demands down is jumbling economic data with financial needs. True, a buildup in aggregate money demands, despite a slowdown in the big "ABC" of activity, would be a first, historically. This by no means rules it out. On the contrary, reversals of historical rules have been more likely than not all through this crisis. A jump in interest rates, coinciding with a rise in tax rates, was an earlier first staged by this crisis while it was still in a relatively benign stage of buildup. So was an intensification of inflation, when relief was indicated by the onset of recession.

Renly good news is Democratic Congressman from Arkansas Wilbur D. Mills' successful back surgery. In my judgment, he has become the key to the entire situation—political, economic, and financial, domestic and international.

On page one of the *New York Times*, September 10, his independent statement on trade is quoted.

"One cannot work to liberalize the movement of goods in the world marketplace if the doors are to be slammed shut

upon what Justice Holmes called 'the marketplace of ideas.'

"I cannot see the United States expanding commercial markets with the Soviet Union if the price is to be paid in the martyrdom of men of genius like Solzhenitsyn and Andrei Sakharov."

This statement proves that, far from being out, he will be around—although not in time to give the Administration the quick on-the-spot action on the trade bill it had promised to foreign creditors. This means no quick action on the tax reform deal.

New Zealand Study Clears Aspirin of Kidney Damage

Medical Tribune World Service

AUCKLAND, NEW ZEALAND—Aspirin does not cause kidney damage, according to a two-year study by New Zealand doctors.

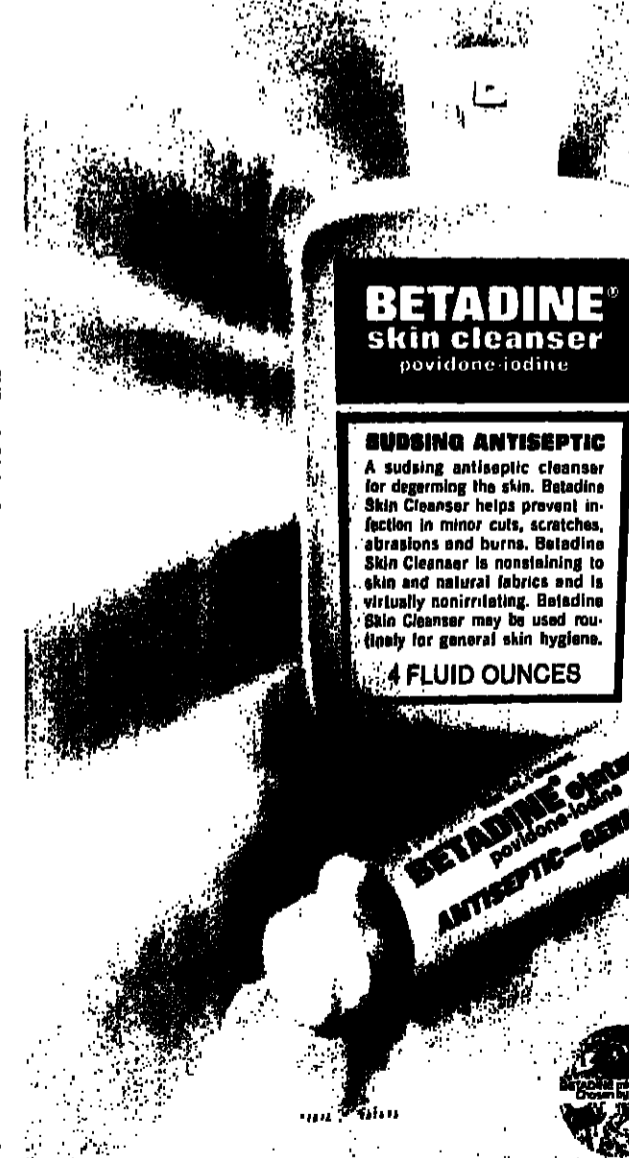
The results were announced by Dr. Richard A. D. Wigley, of the Palmerston North Medical Research Laboratory.

Financed by the New Zealand Rheumatism Foundation, the research covered 900 patients who had been taking aspirin for a long period for relief of rheumatism.

In three patients, aspirin-phenacetin compounds appeared to be responsible for kidney disease, Dr. Wigley said, but none of the patients taking aspirin alone recorded any ill effects to the kidneys.

Broad-spectrum microbicidal power

BETADINE SKIN CLEANSER BETADINE OINTMENT



BETADINE microbicides kill gram-positive and gram-negative bacteria, fungi, viruses, protozoa and yeasts...contain NO hexachlorophene. Virtually non-stinging and nonirritating...nontainting to skin and natural fabrics.

BETADINE SKIN CLEANSER aids in deggering the skin of patients with common pathogens, including *Staph. aureus*...helps prevent recurrence of acute inflammatory skin infections...helps prevent spread of infection in acne pimples...can be used in pyoderma, as a topical adjunct to systemic antimicrobial therapy.

BETADINE OINTMENT acts against organisms commonly encountered in skin and wound infections...indicated in infected stasis ulcers and to prevent infection in minor burns, lacerations and abrasions. Not greasy or sticky...the treated area can be bandaged.

BETADINE SKIN CLEANSER: Available in 4 oz. plastic bottles. In the rare instance of local irritation or sensitivity, discontinue use in the individual.

BETADINE OINTMENT: Available in 1/32 oz. and 1/8 oz. packets, 1 oz. tubes, and 16 oz. (1 lb.) jars.

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Keeping the mild hypertensive in his place

Esidrix (hydrochlorothiazide) alone frequently lowers blood pressure satisfactorily. Its action is gradual, smooth. And it keeps on exerting its antihypertensive effect.

We call this gradual, sustained action "antihypertenacity."

Antihypertenacity—it's what you want in the long-term management of mild hypertension.

Esidrix is still unsurpassed as a basic diuretic/antihypertensive. And many patients with edema rarely need a more potent diuretic.

Contraindications include anuria. Use with caution in patients with impaired renal or hepatic function.

Consult complete literature before prescribing.



that's "Antihypertenacity" Esidrix[®] has it (hydrochlorothiazide)

Esidrix[®]

(hydrochlorothiazide)

Indications: Hypertension and edema. **Contraindications:** Anuria; hypersensitivity to this or other sulfonamide-derived drugs. The routine use of diuretics in an otherwise healthy pregnant woman with or without mild edema is contraindicated and possibly hazardous. **Warnings:** Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte imbalance may precipitate hepatic coma. Thiazides may be additive or potentiative of the action of other antihypertensive drugs. Potentiality occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions are more likely to occur in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported. **Usage in Pregnancy:** Use of thiazides in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the fetus. These hazards include fetal or neonatal

jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. **Nursing Mothers:** Thiazides cross the placental barrier and appear in cord blood and breast milk. **Precautions:** Periodic determination of serum uric acid should be performed at appropriate intervals. Observe patients for clinical signs of fluid or electrolyte imbalance (hypokalemia, hypochloremia, alkalosis, and hyponatremia). Serum electrolyte determinations are particularly important when the patient is vomiting, or when receiving parenteral fluids. Medication such as digitalis may also influence serum uric acid. Warning signs are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea or vomiting. Hypokalemia may develop with thiazides as with other potent diuretics, especially during brisk diuresis, when severe cramps are present, or when concomitant administration of steroids or ACTH. Interference with adequate oral intake of electrolytes will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia, especially with reference to myocardial activity. Any chronic deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction rather than administration of salt, except in rare instances. In actual salt depletion, appropriate replacement is the therapy of choice.

Transient elevations in plasma calcium may occur in patients receiving thiazides, particularly in those with hyperparathyroidism. Pathological changes in the parathyroid gland have been reported in a few patients on prolonged thiazide therapy. Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Latent diabetes may become manifest during thiazide administration. Thiazide drugs may increase the responsiveness of the drug may be enhanced in the post-sympathetic response to norepinephrine. This is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If nitrogen retention indicates onset of progressive renal impairment, consider withholding or Thiazides may decrease serum PBI levels without signs of thyroid disturbance. **Adverse Reactions:** Gastrointestinal—nausea, anorexia, diarrhea, constipation, indigestion (dyspepsia), pancreatitis, pancreatolitis, Central Nervous System—dizziness, vertigo, paresthesias, headache, xanthopsia, Dermatology—hypersensitivity—litzing angitis, Stevens-Johnson syndrome, and other hypersensitivity reactions. Hematology—aplastic anemia, granulocytosis, thrombocytopenia, hypoleukemia. Cardiovascular—orthostatic hypotension may occur and may be potentiated by alcohol, barbiturates, or narcotics. Other—hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness. Whenever

adverse reactions are moderate or severe, reduce dosage or withdraw therapy. **Dosage:** Individualize dosage by titrating for maximum therapeutic response at the lowest possible dose. **Hypertension: Initial—**Usual dose 75 mg daily. **Maintenance—**After a week dosage may be adjusted downward to as little as 25 mg or upward to as much as 100 mg daily. **Combined therapy—**When necessary, other antihypertensives may be added gradually and with caution because of the potentiating effect of this drug. Dosages of ganglionic blockers should be halved. **Edema: Initial—**25 to 200 mg daily for several days. **Maintenance—**25 to 100 mg daily or intermittently. Refractory patients may require up to 200 mg daily. **Supplied:** Tablets, 50 mg (yellow, scored) and 25 mg (pink, scored); bottles of 100, 1000, 5000 and Accu-Pak blister units of 100. **Consult complete literature before prescribing.**

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C I B A

Prompt Surgery Suggested For Tears in Thumb Ligament

Medical Tribune Report

CHARLOTTESVILLE, VA.—Injury to the ulnar collateral ligament of the thumb, a frequent occurrence in competitive sports, is sometimes overlooked or minimized, with resultant residual thumb-index pinch weakness and instability, investigators from the University of Virginia Medical Center have warned.

These sequelae may occur after an adequate course of conservative treatment, causing the patient to request surgery to alleviate the disability, they said. In most sports, they pointed out, thumb-index pinch is a vital function.

They reported on 41 surgical repairs and reconstructions in athletes for ulnar collateral ligament injuries to the thumb from 1961 to 1972.

Twenty-five of the cases were classified as chronic, with a mean interval of 67 days from injury to surgery. Fourteen of the patients in these cases were treated conservatively with four weeks of cast immobilization followed by splinting. This method failed in all 14, and the patients required a subsequent reconstructive procedure because of functional disability.

Sixteen of the 41 patients were in the acute group, with a mean interval of 10 days from the injury to surgery. The surgical result was excellent to good in all 16, the physicians reported.

In 24 of the 25 chronic cases, it was also either good or excellent, but patients in this group averaged 7° more laxity on abduction stress testing when compared with the acute group. Ten of the chronic cases lost 5° or less of extension of the metacarpophalangeal joint compared with the normal side. Four of the 10 patients also lost 5° or less of flexion compared with the uninjured side.

While the patients in the chronic group

exhibited slight reduction in strength of pinch and grip, this did not alter their ability to return to athletic competition. The one poor result in the chronic group was in a 55-year-old skier who had surgery performed 13 weeks after his initial injury and in whom there were degenerative changes in the joint at the time of surgery.

"Over all," the investigators reported, "the best results were obtained in the acute cases who had primary ligamentous repair. Satisfactory or good functional results were accomplished with surgical reconstruction for chronic injuries."

All the athletes who participated in team sports subsequently returned to play at the same position without any noticeable change in their functional ability.

Temporary splinting and taping, the investigators observed, may be used to allow continued athletic participation, if this is feasible in the particular athlete, without seriously jeopardizing the final surgical results.

The authors were Drs. Frank C. McCue III, Michael W. Hakala, James R. Andrews, and Joseph H. Gieck.



Dr. McCue



The ligament is injured by abduction and hyperextension of the thumb and fingers.



Athletic participation can continue despite the ulnar collateral ligament injury when taping is done so that the thumb metacarpophalangeal joint is stabilized to the hand with strips of tape (left). The index finger is then taped to the thumb to prevent excessive abduction at the metacarpophalangeal joint (right).

Confidentiality in MD-Patient Relations

Continued from page 5

is receiving the report and the specific purpose of any inquiry.

Criminal activity on the part of one's patients always causes a serious dilemma. If a doctor learns of a past crime committed by his patient, he should not report this to the authorities unless he has reason to believe that the crime is part of a continuing pattern of criminal behavior and that other persons will be placed at serious risk if the doctor does not report the activity to the police or other authority. In nearly all states, mere failure to report knowledge of a past crime does not make one an accessory to the act; only New Jersey appears to require by statute the reporting of knowledge of a crime, and there do not appear to be any cases where this has been enforced.

Risk Affects Obligation

Similarly, if the physician believes in good faith that a person is in need of hospitalization because of the risk of suicide or behavior which causes imminent danger to others, he is under an obligation to go forward and secure the commitment of the individual. This obligation has been enforced recently by several suits by third parties or their families who have been killed or injured by a patient in treatment who was not committed or by families of patients who have committed suicide. A future column will deal with the dilemma of the physician who, on the one hand, may be sued for false imprisonment if he orders the commitment of a person subsequently found by a court to be not committable and, on the other, by third persons

if he fails to order the commitment. Unfortunately, the major problem in all of this is that, as physicians, your success in predicting erratic behavior is rather low and you are unfortunately very likely to order the commitment of a person who would not have harmed anyone and to fail to commit the person who is in fact extremely dangerous—witness the patient who told the psychiatrist that he had been thinking about shooting people from the tower of the University of Texas.

Now, how to handle the policeman who is still in your waiting room? It is important to emphasize that just because you (tacitly) refuse to give the information, this does not mean that it is not otherwise available. If you are summoned into court and asked the same questions, you may be forced to answer unless there is a statute giving to your patient the privilege of preventing you from answering. Next week, we'll deal with breaches of confidentiality forced by law.

Age of Rats Found Important Factor In Preclinical Evaluation of Drugs

Medical Tribune Report

WEST LAFAYETTE, IND.—The responsiveness of rats to certain centrally acting drugs was found here to increase with age, "clearly demonstrating the importance of the age of the animals as a factor in preclinical drug evaluation studies."

The rats were tested for responses to sodium hexobarbital, chlorpromazine hydrochloride, morphine sulfate, and D-amphetamine sulfate, the Purdue University investigators said.

The I.V. dose of hexobarbital that was required to suppress EEG activity for one second was determined to be approximately 20 per cent lower in animals aged nine to 10 months of age than it was in 2.5- to three-month-olds (59 mg./Kg. against 74 mg./Kg.).

Chlorpromazine produced a greater

hypothermia in older animals at the end of 2.5 hours. Brain levels were the same.

Morphine analgesia was greater in the older rats, particularly at lower doses.

Higher doses of amphetamine produced a greater stimulation of motor activity in the older rats than in the younger.

The investigators were Donald R. Saunders, Tom S. Miya, and Ronald M. Peolino, of the Purdue University School of Pharmacy and Pharmacol Science.

Ceylon Physicians Strike

Medical Tribune World Service

COLOMBO—Some 2,000 physicians went on a 24-hour token strike in Sri Lanka in protest against an alleged assault by policemen on a hospital doctor. The incident occurred after a woman visitor complained she had been refused entry to a ward.

The Mail

• "Please explain the following," wrote Dr. C. Sheridan, of New York University's Institute of Rehabilitation Medicine, in the course of sending us this clipping from the *New York Times*.

"Max Von Sydow played Gregers, the monster of audience all but keeled over with her."

"But all the force was not all with the foreigners. The most interesting new play of the year is an English one: 'The Sea' by Edward Bond. Mr. Bond used to run into idealism, as an awkward, grinning, insane beanpole; Ernst-Hugo Järegård was a magnificently self-centered, spoiled Hjalmar, and when Lena Nyman, his puppylike daughter, killed herself, the regular trouble with the Lord Chamberlain when that official operated as theater censor—he once portrayed Queen Victoria as a Lesbian—but he has steadily gained in repute, and his chilling 'Lear' two years ago was a triumph."

We respond to this touching faith in the column's wisdom, and only after agonizing thought, with the theory that someone at the *Times* went bonkers.

Two fine corrections:

1. Dr. John H. McFadden of Cuyahoga Falls, Ohio, received a report on a patient from a consultant; the following day, from the same consultant's office, came: "Supplemental Report: In the middle of the paragraph regarding the skull, the word should be penile rather than penis body." Pretty stately.

2. Dr. Robert Schwartz of Fredericktown, Pa., sent us a first version and a corrected one of what his dictation had produced in a letter about a case he was considering publishing.

First version: "I have not as yet made a study of the literature, but one of my colleagues did bring to my attention a single reference to this condition in cats and pigs in a textbook on clinical electrocardiography."

Corrected version: "... a single reference to this condition in Katz and Pick's textbook on clinical cardiology."

• From Dr. Theodore Burstein of Alameda, Calif.:

"A student nurse was watching her first operation, a cesarean. The patient was the wife of a staff member, who had exacted a promise from the operator to inform him, as soon as the baby was born, of its sex. During the course of the hurried operation, he forgot his promise and was reminded of it while suturing the abdomen. He turned to his assistant and asked, 'Was that a boy or a girl?' The assistant answered, 'I don't know.' They both turned to the anesthetist and the question was repeated. Again the answer was 'I don't know.'"

"At this point the little nurse spoke. 'Let me see the baby,' she said. 'I can tell!'"

• Dr. Mary L. Cretens of Escanaba, Mich., sent us a surgical note from that city's *Daily Press*:

"When the arm bone heals, surgeons will operate again to splice together the severed radial nerve, which controls finger movement."

And keeps the Administration pretty jumpy.

• An ominous sentence was found in the *Newsletter of the American Academy of Pediatrics* by Keith R. McCloskey of Arlington Heights, Ill.

"Sen. Jacob Javits (R-N.Y.) and Rep. Paul Rogers (D-Fla.) have introduced S.3187 and H.14455, identical bills which would provide \$15 million for research, demonstration, and training in venereal disease prevention and control of universities, hospitals, public and private non-profit organizations..."

Big brother is watching.